HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

468. WATKIN, B. **Does private care provide value for money?** *Nursing Mirror*, Sutton, 1978, Nov. 30, vol. 147, no. 22, pp. 18-20; Dec. 7, vol. 147, no. 23, pp. 22-24; Dec. 14, vol. 147, no. 24, pp. 24-25; Dec. 21, vol. 147, no. 25, pp. 12-13.

This four-part study of private medical care in Great Britain consists of: (i) an examination of the reasons why people turn to the private sector to meet some, or all, of their health needs, and answers some of the criticisms commonly made of the independent sector; (ii) an examination of the cost of treatment in the private sector and some of the organizations financing it; (iii) a report on the work of the Nuffield Nursing Homes Trust, which opened its 30th hospital in 1978; and (iv) a report on American Medical (Europe), which runs the world-famous Harley Street Clinic in London.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 474, 477-479, 514, 604

469. EUROPEAN ECONOMIC COMMUNITY. HOSPITAL COMMITTEE. **Hospitals in the EEC: organisation and terminology.** Copenhagen, Gyldendal, 1978, 464pp.

This book is divided into two parts. The first section, in six languages—English, German, French, Italian, Dutch and Danish, consists of descriptions of hospital organizations in the countries of the EEC arranged under four headings: (i) the different types of hospital according to their function, legal status, geographical coverage and teaching role; (ii) the hierarchy of posts within the medical and nursing professions; (iii) the hospital federations; and (iv) authorities and boards. The second section is a compendium in six languages of hospital terms in most common use within the EEC. The terms appear in the singular and in the same order of languages as in Part I.

470. GASSILLOUD, B. L'hospitalisation en Europe (3e partie), **[Hospitals in Europe—part 3].** *Gestions Hospitalières*, Mantes, 1978, Nov., no. 180, pp. 831-836.

The author summarizes the contents of two previous articles in which he had examined methods of financing hospital services in different European countries. Rising costs demand that the resources available be used as effectively as possible and the achievements of the Swedish Health and Welfare Planning and Rationalization Institute in this field are described. The advantages and disadvantages of the British system of financing through taxation and of the French social insurance schemes are examined. In the former there is always the danger that political pressure will lead to a reduction in the quality or quantity of care provided and in the latter the payer (the patient) has no control over the spender (the hospital). Looking to the future, the author believes that there will be a gradual but ineluctable movement towards an adoption of the British system.

471. Di Giovanni, M. L'hôpital d'aujourd'hui, l'integration et les autres. **[The hospital of today, integration and other factors.]** *Gestions Hospitalières*, Mantes, 1978, Nov., no. 180, pp. 841-843, 844-847, 849-851, 854.

A short description of the variety of hospital structure in Belgium is followed by a discussion of the integrated hospital. The main theme of the argument is that integration will be achieved if hospital doctors work full-time in the hospital and have a proper career structure. Team nursing, communication, and the optimum use of the hours devoted by nursing staff to patient care are briefly mentioned.

472. Carta, G., Bertuglia, A. and Insinga, L. Attrezzature ospedaliere nella provincia di Palermo. **[Provision of hospital services in the province of Palermo.]** *Tecnica Ospedaliera*, Milano, 1978, Sept., vol. 8, no. 9, pp. 31-37.

Movements of population in the province of Palermo have meant that 35 per cent of the population of the province now live in the city of Palermo itself and 20 per cent live in the coastal region. This is one of the main reasons for the serious imbalance in hospital provision in the province as a whole, since the majority of both public and private hospitals and clinics are concentrated in the capital. The bed/population ratio in Palermo itself is 8.30/1,000 while for the rest of the province it is 1.63/1,000. The Region should take immediate steps to remedy this situation. Relevant data are supplied in four maps and four tables.

473. Moss, F. E. and Halamandaris, V. J. **Too old, too sick, too bad: nursing homes in America.** Germantown, Md., Aspen Systems Corporation, 1977, xvii, 326pp. $15.95

This book describes the current state of nursing homes in the United States, and what needs to be done. The book is in four sections and covers: (i) nursing home problems; (ii) causes of nursing home abuses; (iii) positive aspects in long-term care; and (iv) reforms. The history of nursing homes in the United States and the work carried out in nursing homes today is outlined. At present one third of the money paid out in the $15 billion Medicaid Scheme is spent on nursing home fees, and this book is an attempt to reconcile the conflicting opinions about nursing homes and their potential abuse in the United States.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract No. 515

474. Redstone, L. G. **Hospitals and health care facilities.** 2nd edition. New York & London, McGraw-Hill, 1978, xi, 193pp. £18.35

This guide was compiled from articles in the *Architectural Record* published during the last five years and illustrates step-by-step the procedures for making informed planning decisions. The book is divided into five sections: health care planning—theory and practice; new hospitals; updating existing facilities; health related facilities and combined medical treatment. The coverage includes more than 40 examples of new and renovated hospitals throughout the world, ranging from small private clinics to large public hospitals, research oriented facilities connected with universities and other health-related organizations. Photographs and plans for each of the health care facilities are included.

HOSPITAL DESIGN

See also Abstract Nos. 474, 482

475. Werkmodel voor een basisziekenhuis. **[Summary of a report on a model for basic hospital design.]** *Ziekenhuis*, Utrecht, 1978, Nov. 1, vol. 8, no. 21, pp. 548-551.

The model is an interim design to be discussed with the NZR (National Hospital Council) before completion. The minimum size for the standard hospital is calculated for three categories of hospital: (i) the 'basic' hospital which provides for 85 per cent of the population of its catchment area; (ii) the 'central' hospital which has a wider function; and (iii) the 'top' hospital which supplies a total package of services. The number of beds for the basic hospital should be between 200 for a 60,000 population of younger people and 450 for a 110,000 population of older people. Regionalization for the country should be on a functional basis with 'large regions' providing complete medical services, a balanced distribution of basic hospitals and decentralization of services within the regions. The internal structure is based on composition of staff and quality and provision of services. To ensure continuity of medical care at least two specialists should be available for the three basic specialties (surgery, medicine, gynaecology and obstetrics) and for anaesthetics. The nursing units suggested are: one seven-bedded special care unit; one 25-bedded children's unit; and four ward units of 43 beds each. Other matters considered are: staffing of departments; transfer of patients to the central hospital; and a commission on safety and hygiene. The paper includes a working model diagram.

476. ANDREINI, A. Elementi del processo di decision-making applicato alle costruzioni ospedaliere. **[Features of the decision-making process as applied to hospital construction.]** *Tecnica Ospedaliera*, Milano, 1978, Nov., vol. 8, no. 11, pp. 21-35.

This is an introduction to the theory and practice of value management in relation to hospital construction which is based on the author's experience on a course at the University of Oregon. All the data relating to planning an ancillary building for the Sacred Heart General Hospital Medical Center in Eugene, Oregon, were collected and subjected to critical analysis. In addition to purely technological data, the physical environment, the ecology of the area, and the economic and legal considerations were examined, and the decision-making process adopted by the planner was recreated and analyzed. The relationships of all the parameters included in the planning process are presented in matrix form in two tables. The account also includes nine photographs and plans of the ancillary building.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 482

477. BOTELLA, A., YEBENES, R. R. and CASARES, A. La nueva residencia sanitaria de Guadalajara. **[The new hospital of Guadalajara.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, July/Aug., vol. 2, no. 4, pp. 48-54.

A short description is given, with seven diagrams and sketches, of the new general hospital in Guadalajara, Spain, which should be ready this year. The hospital will

have 487 beds, 70 of these in single rooms. The hospital is of conventional design, five ward blocks rising from a wide base which houses all the administrative, general, technical, and medical departments. The cost of construction, equipment, and landscaping will be 752,000,000 pesetas.

478. CABELLO, R. Residencia Sanitaria de la Seguridad Social Cadiz. **[Social Security health centre, Cadiz.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, July/Aug., vol. 2, no. 4, pp. 24-29.

A health complex consisting of a general hospital, maternity hospital, rehabilitation centre, cobalt therapy and nuclear medicine unit, and school of nursing has been completed in Cadiz. Because of the limitations of the site, the building is compact. A four-floor rectangle contains the technical services, general services, theatres, and clinics, and above this rectangle rise the six or seven-floor ward blocks. The complex has a total of 958 beds and cost 987,000,000 pesetas. This brief description of the complex includes three drawings and two floor plans.

479. FLOREZ PLAZAS, D. F. and LOPEZ-FANDO DE CASTRO, L. Teoria arquitectónica de los hospitales comarcales. **[Architectural theory for regional hospitals.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, July/Aug., vol. 2, no. 4, pp. 36-47.

The authors outline the factors to be considered and the steps to be taken by the architect when planning a regional hospital. These include considerations of the size of the population to be served and therefore the capacity of the hospital, the level of services to be provided, room for expansion, the water and power supplies which will be needed, the individual departments required and the amount of space to be allocated to each, and the number of wards required. They sketch their designs for a 100-bed and 150-bed hospital and list in two tables the departments needed and the amount of space to be allotted to each. In a third table they list the number of out-patient clinics which will be needed.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract No. 597

480. VESTERDAL, J. Den bygningsmässige indretning af en børneafdeling. **[Construction planning requirements for a paediatric unit.]** *Tidsskrift for danske Sygehuse*, København, 1978, Oct., vol. 54, no. 9, pp. 148-154.

The paediatric unit must be subdivided into wards for the newborn (including premature babies), an isolation unit, and wards for infants up to three years of age and children from three to 15. It must be possible to isolate all rooms completely from each other. Rooms should have a maximum of four beds (though one or two in isolation rooms), with a glass wall for observation. Oxygen and air supplies must be piped, as cylinders are a danger on children's wards. All toilets must be of normal-size and of the wash-down type, taps must have long handles operable by staff elbows and children's hands. Each section must have a nurse's office and staff conference room, a sluice and kitchen, changing rooms, medicine room and examination room. A room in which nursing mothers can sleep near the sick baby is essential, and the

ward must be easy to get at and totally isolated from all other rooms. The 20-bed isolation unit must have microphones and loudspeakers in the ceiling to allow audio-communication without physical contact. Details are also given of the three-bed pre-toddlers unit, the four-bed wards for older children, hobby room, schoolrooms, outdoor play area, children's reception facilities, out-patients' unit, conference room, a room for psychological examinations, and a consulting room for doctors and social welfare workers. In addition, there has to be a milk kitchen and the necessary laboratory facilities. It is easy to satisfy the above requirements when planning new buildings, but adapting existing buildings can be very expensive, and demands a considerable increase in staff. The article is illustrated by four interior photographs.

NURSES' HOMES

481. ROYAL COLLEGE OF NURSING. ASSOCIATION OF NURSING STUDENTS. **Focus on nurses' residences: report of a survey on the standards within and the management of nurses' residences, and the effectiveness of residents' committees.** London, Royal College of Nursing, 1978, [ii], 46pp.

This survey was conducted to give a more accurate picture of nurses' residences in Great Britain, their management and the effectiveness of residents' committees. This allowed the Rcn Association of Nursing Students Executive Committee to judge the size of the problems that had been brought to its attention objectively, before making decisions on what form any further action should take. The findings of the survey are detailed. Sample copies of the questionnaire and of the covering letter are included.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

482. TYLER, P. A. and JAMES, W. P. **Engineering building services for nucleus hospitals.** *Hospital Engineering*, London, 1978, Nov., vol. 32, no. 9, pp. 7-16.

The nucleus hospital comes to terms with the prospect of a reduced level of capital investment for some time to come. It provides for a strictly limited content (300 beds) within a work cost below three million pounds as a first phase of a hospital which could grow to take up to 600 to 900 beds. Numerous applications of the nucleus principle are under active consideration throughout the United Kingdom and some of these are in the planning and design stages. This paper describes three schemes which appear to be the front runners at the moment, at Redhill, Newham and Maidstone. Plans and diagrams are included.

483. PLAZY, C. Le syndicat inter-hospitalier de secteur. **[Regional inter-hospital network.]** *Hospitalier*, Mantes, 1978, Nov., no. 346, pp. 35-40.

The author describes the advantages of having a centrally located inter-hospital technical services network, serving all the hospitals in a given area. This service network

would be responsible for planning new building; for the general running and maintenance of existing hospitals; for the installation and maintenance of bio-medical equipment, for security; and for laundry services. The network would have its own budget and be paid by each hospital pro rata for services provided. A network of this type would be of particular value to smaller hospitals which cannot afford to employ all the qualified staff they require.

ARTIFICIAL LIGHTING

484. MAINARDI, R. L'illuminazione delle stanze di degenza ospedaliera. **[Lighting of hospital patients' beds.]** *Tecnica Ospedaliera*, Milano, 1978, Sept., vol. 8, no. 9, pp. 56-62.

An explanation of the concepts of visual sensation, visual performance, and dazzle is followed by a description of the various types of lighting required for a hospital patient's room—general illumination for day-time and night-time, a lamp for medical examinations, a personal or reading lamp, and a night light for occasional use. The amount of illumination required for each type is given and the siting of the light fittings is discussed. Four photographs of Brocca equipment are included.

485. BARTLETT, D. **Operating theatre lighting.** *NATNews*, Matlock, 1978, Nov., vol. 15, no. 11, pp. 24, 26, 28, 30.

This short paper aims to highlight the whole question of operating theatre lighting and to show that it is not just the choice of operating light which governs the 'comfort' and efficiency of the surgical team and the surgeon in particular. Three main points have to taken into consideration: brightness, glare and colour. Some of the problems that these impose are discussed. Also discussed are three other factors relevant to the operating light: shadow reduction, elimination of heat, and flexibility of use. Advice is given on purchasing surgical lighting.

COMMUNICATION SYSTEMS

486. MCCORKLE, J. E. and others. **Basic telecommunications for emergency medical services.** Cambridge, Mass., Ballinger, 1978, xix, 152pp. £8.85

This guidebook provides staff not trained in telecommunications, with a general understanding of the application, design and implementation of a supporting Emergency Medical Services (EMS) communications system. The authors include a guide to implementing a detailed communications plan, indicating the information planners must provide to communications consultants responsible for systems specification. Aspects considered include: the EMS Council; the EMS planning report; capabilities of EMS telecommunications; communications plan; consultants; EMS communications equipment and systems configuration; and specification. Three appendices include information on: the Federal Communications Commission and EMS; funding; and selected references and Resource Agencies. A glossary of terms is also included.

HEATING

See also Abstract No. 490, 519

487. BRETHERTON, E. J. and BRIGGS, R. **Monitoring the effects of NHS investment in energy conservation—a management task.** *Hospital Engineering*, London, 1978, Oct., vol. 32, no. 8, pp. 13-16, 18-19.

The National Health Service in England and Wales has now embarked on a £28 million programme of investment in energy conservation as part of a government objective to bring public sector buildings up to a minimum standard of energy efficiency during the next 10 years. Four essential steps need to be taken to establish effective management control of the programme: (i) monitor energy consumption over the five-year period 1977/78 to 1981/82; (ii) make allowance for the variable effects of weather and significant site changes; (iii) represent energy consumption in a form which enables the process of monitoring to be generally and easily understood; and (iv) establish a routine procedure for analyzing energy consumption. The means by which these four steps can be taken are embodied in an energy monitoring (EM) sheet produced by a working party in the West Midlands Region. A completed EM sheet is reproduced and its layout and use are described. Provision is made on the EM sheet for plotting profiles of energy consumption for space heating and non-space heating fuels. The analysis and interpretation of the profiles is outlined.

488. BLAN, G. J. and BROWNE, K. H. **Energy management: total program considers all building's systems.** *Hospitals*, Chicago, 1978, Sept. 16, vol. 52, no. 18, pp. 121-122, 124, 126, 128, 130.

This paper describes how St. John Medical Center, Tulsa, Oklahoma, is meeting the challenge of increased energy costs and reduced availability while maintaining high-quality care by applying the concept of total energy management. The programme was divided into three phases: (i) quality control phase, including a building/staff survey, audit of energy-consuming equipment and initial proposals involving no capital investment costs; (ii) a proposal phase, including an in-depth study of the centre's heating, air-conditioning, lighting and power systems, auxiliary services, and work schedules and development of co-ordinated energy conservation proposals, including cost and payback data; and (iii) a construction phase, involving the implementation of the proposals as listed in order of priority in phase 2. Cumulative savings from implementation of all energy conservation proposals were estimated to be two million dollars during a five-year period.

489. BAYOD, D. J. R.-C. Sistemas de recuperacion de energia en instalaciones de climatizacion de hospitales. Aplicacion practica a la instalacion de la residencia sanitaria de Sagunto (Valencia). **[Methods of recovering energy from air conditioning plant in hospitals: practical application at Sagunto health centre (Valencia).]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 71-77.

An introduction to the theory and practice of thermal energy recovery, with particular reference to recovery of heat from air conditioning systems in hospitals, is followed by a description of the installation of a heat recovery system in a hospital in the province

of Valencia, where rotary heat interchangers are used. There is a diagram of the installation together with a series of six graphs showing relevant temperature data.

BOILERS AND BOILER HOUSES

490. HILEY, R. **Pre-heating steam boiler feed water—a practical application for solar heating.** *Hospital Engineering*, London, 1978, Oct., vol. 32, no. 8, pp. 21-22, 24.

The growing need for energy conservation is generally accepted. Apart from economizing on fuel consumption, further possibilities include the use of alternative energy sources such as wind power, wave power and solar energy. In many applications, it is impossible to completely dispense with conventional fuels, and alternative sources can only be regarded as a means of reducing fuel consumption, as in the pre-heating of steam boiler feed water. This paper indicates that the installation of a solar pre-heating system can be both practical and economically viable. It discusses the pre-heating concept and the relative merits of glazed and unglazed solar collectors. A simple pre-heating steam boiler is described and an analysis of its efficiency is presented.

VENTILATION AND AIR CONDITIONING

See Abstract No. 519

INSULATION AGAINST SOUND AND TEMPERATURE

491. WAGSTAFF, T. **Noise control in health buildings.** *Hospital Engineering* London, 1978, Oct., vol. 32, no. 8, pp. 6-8, 10-12.

This paper first identifies the difference between sound and noise. It then goes on to examine what noise control is, why it is necessary, when and by whom it is carried out and how it is approached. If noise control is considered early, it can be implemented at the design and construction stages. Noise should not be considered in isolation but as something totally integrated with the spatial, visual and thermal environmental design. This integrated design will achieve: an acceptable environment for patient and staff activities; safe working conditions; and harmony with the community. Noise control in its simplest form need not be expensive. Many commonsense approaches and good engineering practices automatically lead to the designing out of noise problems.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

See Abstract No. 484

EQUIPMENT GENERALLY

See Abstract No. 544

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract No. 566

RECRUITMENT AND MANPOWER

See also Abstract Nos. 497, 502

492. Bons, J. P. Controle op de inzet van personeel. **[Supervision of hospital staff distribution.]** *Ziekenhuis*, Utrecht, 1978, Nov. 1, vol. 8, no. 21, pp. 565-567.

To cut down staffing costs a programme was worked out by the AISZ bureau (a branch of the Sazinon foundation of co-operating hospitals in the north-east of the Netherlands). Every four weeks rotas are issued to every department to allocate staff, or sections of the staff, in the most efficient way. The following items are given: (i) number of hours to be paid extra for irregular times of each staff member; (ii) for each department and for each staff member the number of days-off if these differ from the entitled amount for the period as well as the number of days-off still due; (iii) the number of staff daily required for each department; (iv) the records of sections of staff stating the number of weeks of training service completed and those that remain to be completed together with the total number of weeks worked per department; (v) the records of training service duties of each person per day as well as the total for each department and the number of sick days during the period. Data processing and preparing the rota for approximately 250 to 400 staff will cost about £125 to £175. Entry costs (once only) for the scheme are within a maximum of £250. The paper includes six tables.

SALARIES AND SUPERANNUATION

See Abstract No. 503

STAFF MANAGEMENT

See Abstract Nos. 492, 498, 622

STAFF TRAINING

See Abstract Nos. 494, 499-501, 508-511, 537, 568, 569, 599, 601

STAFF WELFARE

See Abstract Nos. 500, 502

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 555, 566, 572, 573, 576, 579

493. DEPARTMENT OF HEALTH AND SOCIAL SECURITY, SCOTTISH HOME AND HEALTH DEPARTMENT and WELSH OFFICE. **Medical manpower: the next twenty years, a discussion paper.** London, Her Majesty's Stationery Office, 1978, ix, 84pp. £2.00.

This paper presents information about future prospects for the supply and demand of doctors in Great Britain. It sets out for debate the assumptions underlying the present medical manpower policy and the broad developments that can be expected to flow from that policy. It also attempts to identify areas where further study or research is needed. Aspects considered include: a historical survey of early attempts to examine medical forecasting; the problems of forecasting; the constraints imposed by availability of resources; the factors determining the demand for doctors; and projections of future supply. Three appendices are included on: the present stock of doctors and changes over time, medical school input and output, migration of doctors and population; comparisons with other countries; and the technical details of the projection.

494. COOMBS, R. H. **Mastering medicine: professional socialization in medical school.** New York, Free Press & London, Collier Macmillan, 1978, xiv, 288pp. £11.95

Every year between five to 10 per cent of all students drop out of medical school in the United States. Representative studies indicate that another 20 to 30 per cent continue their medical studies at the expense of their emotional, physical or mental health. This book traces an entire class of medical students from the time of their acceptance into medical school through four years of training and graduation, to the beginning of residency schemes. Each individual in the class was studied at seven points in his or her career and these time-differentiated findings illustrate those evolutionary damages in attitudes, behaviour and values that students experience at various stages of the educational process. How and when students decide on a medical career and eventually select a specialty are examined as important aspects of their process.

NURSING STAFF

See also Abstract Nos. 540, 563, 567, 578, 590

495. ELLIS, B. **The all-RN staff: why not?** *Hospitals*, Chicago, 1978, Oct. 16, vol. 52, no. 20, pp. 107-108, 110, 112.

The emphasis on cost containment and consumer satisfaction has spurred a new upsurge in interest in all-registered nurse staffing. In late July, professional nurses from around the United States attended the Conference on the All-RN Nursing Staff to develop strategies for reinstating the nurse-patient relationship that was theirs before

care became fragmentized in the interest of efficiency. Some of the views expressed at the conference are summarized in this paper. Data increasingly show that an all-RN staff does not necessarily cost more and markedly improves the quality of patient care. Although obstacles to the implementation of such a policy exist, they are not insurmountable.

496. POOL, J. J. Verpleegkunde is niet professioneel. **[Nursing is not a profession (but an occupation).]** *Ziekenhuis*, Utrecht, 1978, Nov. 1, vol. 8, no. 21, pp. 556-561.

The author discusses the differences between a profession and an occupation, such as knowledge acquired by long training, the importance of the profession to society, self-criticism of its own performance, recognition by law, and professional culture including ethics, conduct, language, norms and values. Then there are structural criteria such as training, education, qualifications, legal protection and professional organizations, and individual criteria such as membership of a professional body, reading professional journals, attending conferences, and lectures. To investigate the attitudes of both medical and nursing staff a survey was carried out in six general hospitals. The 24 questions were similar for both groups, ranging over membership and reference use of their professional organizations, attitude towards society, vocation, financial renumeration, professional autonomy. It was found that the nursing staff was less professionally organized than the medical staff, read less professional literature, had less autonomy and shorter training. The turnover of nurses was also high and the nurse-patient relationship secondary to that of doctor-patient. In both groups higher ranks were the most professionally orientated. The conclusion is that nursing is not professional in the same way as the medical profession. The paper includes four tables, one diagram and a list of references.

497. SEYBOLT, J. W., PAVETT, C. and WALKER, D. D. **Turnover among nurses: it can be managed.** *Journal of Nursing Administration*, Wakefield, MA., 1978, Sept., vol. 8, no. 9, pp. 4-9.

This article describes a project involving two years of research at a university hospital with a high turnover of nursing staff. The study used a theoretical model to offer practical suggestions to nursing administrators dealing with turnover. An attitude survey was presented to 242 nurses with differing qualifications. Types of data collected included: (i) turnover; (ii) satisfaction data; (iii) mobility data; and (iv) performance measures. Three different aspects of the nurse's perception of her role were measured. Analysis revealed that the responses of those who subsequently left the hospital were different from those who stayed, the leaver being less satisfied and giving a less good overall performance. Those who left saw little connection between good job performance and better job satisfaction. A survey of this type can reveal areas where changes involving job and responsibility adjustments may serve to reduce the rate of turnover.

498. WILSON-BARNETT, J. and HANCOCK, C. **A future for ward-based nursing officers?** *Nursing Mirror*, Sutton, 1978, Nov. 30, vol. 147, no. 22, pp. 27-29.

Some problems and criticisms of the conventional nursing officer role are examined, together with the need for a clinical career structure. At a large non-teaching hospital in London, an experimental post was introduced of a nursing officer based on one ward,

with managerial responsibility for the other wards of the unit. A charge nurse of one of the men's general surgical wards was offered the post of nursing officer (surgical unit) for the experimental period. To evaluate the experiment, interviews were held with all trained staff four weeks before the new post was established and nine weeks after it had been fully established (three months after the first interviews). Approval of the post by so many of those interviewed and the high job satisfaction obtained by the ward-based nursing officer lead to a conclusion that this role is successful and worthy of further consideration.

499. **Continuing education—who cares?** *Nursing Administration Quarterly*, Germantown, Md., 1978, vol. 2, no. 2, pp. 1-90.

The major feature of this special issue on continuing education for nurses is a series of papers on the staff development programme at University Hospital, University of Washington, Seattle. There are also papers on: evaluating continuing education; administrative support for the clinical specialist placed in the continuing education department; continuing education as a treatment for outdatedness; contra-indications for in-service training; and educating new graduate nurses in a family care internship. There is also a forum on continuing education.

500. EDWARDS, P. **Problems of communication facing overseas nurses.** *Nursing Times*, London, 1978, Nov. 30, vol. 74, no. 33, occasional papers, pp. 133-136.

This study of overseas nurses training in England and Wales is based on interviews with 30 principal nursing officers for education, a questionnaire survey of 219 overseas nurse learners with 59 indigenous learners as controls, and eight weeks' participant observation in the classrooms and wards of eight training schools. The results are discussed under three headings: social and psychological problems; linguistic problems; and problems arising from education background. Recommendations include: (i) for the learners—the provision of a proper orientation course (with a language component) which includes all nurse learners; (ii) for tutors—an improvement in their teacher training regarding methodology and classroom presentation, with a component on overseas learners' problems and their background; and (iii) for trained ward staff—seminars to be held jointly with tutorial staff on the problems of overseas learners and guidance on how they might best be helped.

501. FARLEY, M. **The objectives of student nurse training in the operating theatres.** *NATNews*, Matlock, 1978, Oct., vol. 15, no. 10, pp. 8-12, 15.

After outlining a plan for training nurses for operating theatre work, the author carried out further research in this field. Questionnaires were sent to a random sample of Directors of Nursing Education in England and Wales, to be forwarded to those concerned with training student nurses in operating theatre work. A total of 43 replies, representing a 75 per cent response, were received from various grades of teaching staff and 34 stated that a planned training programme was in operation. However, although most students received theatre training at the end of their second or at the start of their third year, they spent a varied number of weeks in the theatre, were often taught a limited number of procedures and were assessed by a variety of methods. The most common suggestion made for improvements in theatre training was that a full-time clinical teacher should be employed solely for this purpose. The author considers

there is scope for further research in this area with the aim of formulating a national syllabus for nurse training in operating theatre work.

502. ULLRICH, R. A. **Herzberg revisited: factors in job satisfaction.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, Oct., vol. 8, no. 10, pp. 19-24.

In an attempt to discover the reasons for a high rate of turnover, 47 nurses at a private general hospital in the United States were interviewed with regard to work motivation. Each job experience was analyzed into factors which produced certain feelings, effects which produced satisfaction or otherwise, and effects which resulted in certain behaviours and attitudes. The results showed that: (i) feelings of achievement and levels of responsibility did not necessarily produce job satisfaction; and (ii) job disatisfaction was often the reason for leaving a hospital. An organization may be unable to provide sufficient rewards to meet employee aspirations, or it may exceed aspirations by providing more of one factor e.g. responsibility, than an employee finds rewarding. A major responsibility of nursing administrators is to arrange a working environment in which nurses can realize aspirations related to their work and communicate easily with their supervisors.

503. BRACKEN, R. L. and CHRISTMAN, L. **An incentive program designed to develop and reward clinical competence.** *Journal of Nursing Administration*, Wakefield, Mass., 1978, Oct., vol. 8, no. 10, pp. 8-18.

In 1974 the Rush-Presbyterian-St. Luke's Medical Center, Chicago, developed a system of behaviour criteria for four levels of nursing practice. Using a mathematical model, a system of job evaluation was devised, based on: (i) job knowledge; (ii) the degree of judgment needed; and (iii) the level of responsibility involved. A total 'worth' value of a job is then 'priced' in order to calculate the appropriate salary. A computer line fitting financial value and 'worth' value for key posts forms the outline of a salary structure. Positions of similar worth are grouped into 'zones of worth' corresponding to the different salary ranges. With the process described, a salary structure for all nursing activities can be systematically developed, thus ensuring quality of care through a calculated system of incentives.

504. NURSE, G. **What is counselling?** *Midwife, Health Visitor & Community Nurse*, London, 1978, Oct., vol. 14, no. 10, pp. 352, 354-355.

The main components of counselling between patient and nurse, or other helper, are: (i) empathic understanding; (ii) respect for the individual; and (iii) genuineness. There is a need for further clarification on the subject of confidentiality, but the author considers that no information should be passed on without preferably the consent of, but certainly the knowledge of, the individual being helped. Inherent qualities needed for the work of counselling can be developed through planned learning during both basic and post-basic nursing education.

505. **Rediscovering the patient.** *Nursing Times*, London, 1978, Nov. 30, vol. 74, no. 48, supplement pp. 1-24.

A growing number of nurses are now experimenting with the nursing process in hospitals throughout the country. This special supplement examines the problems of applying theory to real life in the wards and shows how the process can be used to

enhance patient care. This is carried out through the eyes of nurses at two centres: nursing degree students at the University of Manchester who gain their clinical experience at the Royal Infirmary; and nurse researchers and ward sisters at the London Hospital. A description is given of how systematic care planning is being introduced into one ward at Manchester and two of the care plans used and written in the ward are presented. At the London Hospital, researchers have been studying the availability of nursing staff, the means of deploying nursing skills and methods of ensuring that nursing care was appropriately prescribed, given and received by the patient. The papers on this project consider: prescribing for nursing care; introducing individual care plans; taking admission histories; and the introduction of care plans on a psychogeriatric ward.

506. **Why do we need the nursing process?** *Nursing Times*, London, 1978, Nov. 30, vol. 74, no. 48, pp. 1984-1988.

These three papers given at a study day organized by the Scottish Home and Health Department Nursing Research Advisory Group examine current thought on the process of nursing. The question of the title was answered: from the legal point of view by a solicitor; from the practical point of view by an area nursing officer; and from the professional point of view by the deputy director of a university nursing research unit.

507. **Research: impact on nursing care.** *Nursing Administration Quarterly*, Germantown, Md., 1978, vol. 2, no. 4, pp. 1-114.

The aim of this special issue is to help nursing administrators become more knowledgeable and to take more interest in the use of research in practice. The nine papers are on: research in nursing administration; bringing research to the bedside; nursing administrators' roles in research; impact on patient care; research and the American Nurses' Association; issues in evaluation of nursing programmes; measuring quality outcomes; job satisfaction research; and the impact of task characteristics on employee response. There is also a short forum on nursing research.

508. KNUDSEN, A. Kun de kan undervise sygeplejeelever på operationsafdelingen. **[Only experienced operating theatre nurses can teach trainee nurses operating theatre work.]** *Sygeplejersken*, København, 1978, Nov. 1, no. 43, pp. 6-8, 27.

The only staff category qualified to teach student nurses the basic principles of operating theatre work are experienced theatre nurses. Auxiliaries may be able to teach certain purely practical routines, and theatre assistants may be able to relieve trained nurses of certain tasks in theatre, but their teaching ability is limited. The declared aims of operating nurse training at Odense Hospital are to ensure continuity of patient care; to give the patient individualized psychological and physiological support before, during and after operation; to avoid unnecessary waiting time; to administer staff and technical resources economically, and to work within and expand the nurse's field of knowledge and competence. In other words, she requires: (i) an intensive observation and communication technique; (ii) intensive nursing abilities in association with the care of the anaesthetized patient; and (iii) intensive application of anti-infective prophylaxis. The introductory course given to trainee orthopaedic nurses at Odense lasts 12 weeks, compared with a Health Department minimum requirement of eight weeks. Eight weeks is regarded as too short a training period, and

the trainee risks being no more than a passive observer. An ideal course of instruction would last for one to two years.

509. THRANE, S. Operationssygeplejerskers arbejdsområde: øget viden om den totale patientpleje ved tilbud om rotation. **[The field of work of the operating theatre nurse: it is essential for her to keep up to date with all aspects of patient care by working in rotation in other units.]** *Sygeplejersken*, København, 1978, Nov. 1, no. 43, pp. 4-7.

A theatre nurse's responsibilities comprise her clinical, administrative, teaching and specialist functions, much of her time being spent on indirect patient care. The subject of improving patient care by theatre nurses also implies questioning the need for theatre nurses as no nursing is required. The answer is in the affirmative, the nurse's prime task being to ensure that patients are fully prepared mentally and physically for operation, and taken through the process without delay or unnecessary distress. The theatre nurse is the obvious person to visit the patient pre- and post-operatively and provide all necessary information. Theatre nurses need refresher periods outside theatre, (e.g. in the form of rotation in other units within the specialty): wards, theatre, recovery. Facilities for this should be on offer at all hospitals and stressed to applicants for posts. Nurse-to-nurse communication is a vital aspect of nursing; many hospitals have introduced 'Problem Notes', in which problems and other observations of interest are recorded and passed on with the patient. Theatre nurses are expected to expand their expertise continually, but must not overlap with doctors' or medico-engineers' fields of responsibility. The programme for the introductory week's course given to new theatre nurses at Odense Hospital is reproduced.

510. STAFFORD HARDY, V. G. **The emergency nurse practitioner: the role and training of an emerging health professional.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, Oct., vol. 7, no. 10, pp. 372-376.

This article describes the role and training of the nurse practitioner, compares them with that of the physician's assistant and examines the need for nurse practitioners in the emergency department. In 1974 there were about 1,500 qualified nurse practitioners in the United States. The emphasis in their training is on the treatment of chronic and well patients, and studies have shown that nurse practitioners give a high quality of care. An increasing number of patients are using emergency departments as sources of non-emergency care and nurse practitioners can play an important part in providing counselling and health education. In consultation with a physician, they can also assess patients and administer drugs. The concept of the nurse practitioner is new, but as health care needs and costs increase, the demand for this expanding nursing role must be met by the setting up of more training schemes.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See also Abstract No. 569

511. OVIATT, V. **Hospital engineering education in the U.S.A.** *Hospital Engineering*, London, 1978, Dec., vol. 32, no. 10, pp. 16-18.

The varied educational programmes offered to and for hospital engineers in the

United States are described. Probably the most successful have been those classified as continuing education and technical education. The development of a successful graduate professional degree course presents an enigma, and maybe as such, it is not needed. If not, some other means of formal hospital engineering education is required for the graduate engineer entering this environment. At this time the work study approach and the residency programme of the American Society for Hospital Engineering seem the most promising in the United States.

ANCILLARY STAFF

See Abstract Nos. 563-565

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 472, 476, 483, 487, 528, 530-531, 581

512. RAKICH, J. S. and DARR, K., editors. **Hospital organization and management: text and readings.** 2nd edition. New York & London, S.P. Medical and Scientific Books, 1978, 473pp. £13.45

The aim of this book is to offer a compilation of readings on hospital organization and management in the United States from a managerial point of view. The book is in five sections. Part I considers the hospital as an organization; part II, the management of hospital staff; part III, hospital unions; part IV, quantitative approaches to decision-making; and part V, health care policy issues and trends. Each of the five parts contains introductions by the editors, and also select bibliographies.

513. MACSTRAVIC, R. E. **Determining health needs.** Ann Arbor, Mich., Health Administration Press, School of Public Health, University of Michigan, 1978, ix, 268pp. $17.50

This book presents a model for defining health needs in the United States and alternative methods for evaluating these needs. The ultimate success in planning health services depends upon the determination of the health needs of the community. Aspects relating to these needs are discussed and include: basic concepts of need; service constituency; determining the need for health services use; current and future use of health services; resource requirements; organization and location of resources; and acute in-patient, long-term care, out-patient and casualty services in hospitals.

514. KOVNER, A. R. and NEUHAUSER, D. **Health services management: readings and commentary.** Ann Arbor, Mich., Health Administration Press, School of Public Health, University of Michigan, 1978, [ix], 566pp.

The aim of this book is to bridge the gap between the theory and practice of health services management by organizing readings according to a theoretical framework and by providing commentaries which interrelate readings and theory. The readings have been selected for their relevance to current problems encountered by health

service organizations in the United States. The readings come under seven headings: introduction; the role of the manager; organizational design; control; physician integration; adaptation; and accountability. An annotated bibliography is included (pp. 537-550) together with a list of relevant journals.

515. SEAVER, D. and DWYER, T. **Joint planning—how a hospital and a city carried it off.** *Hospitals*, Chicago, 1978, Sept. 16, vol. 52, no. 18, pp. 67-71.

The 1,159-bed Methodist Hospital of Indiana, Indianapolis, and the City of Indianapolis both having a strong commitment to redevelopment, designed a long-range project in which the hospital, as the dominant permanent institution of its inner-city neighbourhood, played an important part in solving the problems faced by the entire community. Steps in the planning process were: (i) working out the mechanics of the relationship among the three leading forces—the city's Department of Metropolitan Development, the planning and architectural firm, and the hospital; (ii) defining the geographical boundaries of the planning area; (iii) preparing a data inventory; (iv) public meetings; and (v) hospital staff survey. The planning process culminated in a 120-page *Methodist Hospital Vicinity Plan.*

516. THOMPSON, J. D. **Epidemiology and health services administration: future relationships in practice and education.** *Milbank Memorial Fund Quarterly, Health and Society*, New York, 1978, vol. 56, no. 3, pp. 253-273.

The efforts of Florence Nightingale to persuade hospitals to adopt a standard set of statistics for each patient are outlined, which is an objective still not realized. The principal thesis of this paper is that planning, management and evaluation, without quality control, cost analysis or the measurement of the effect of medical intervention on the national history of diseases and the incidence and prevalence of that disease, lack both epidemiological rigour and practical relevance. Problems include development, validation and application of a practical, medically meaningful, descriptive and analytical model that is statistically stable; and derivation of a control model sensitive enough to monitor the operational aspects of the system and to detect changes in the diagnostic mix patterns that might reflect changes in the natural history of a disease. One approach is the automatic grouping (AUTOGRP) model, which is applied to Medicare patients in 34 Connecticut hospitals and, in an appendix, to patients of Yale-New Haven Hospital. The implications for the curriculum for health services administrators are discussed.

GOVERNING BODIES, COMMITTEES

517. UMBDENSTOCK, R. J. **We only have to ask.** *Hospitals*, Chicago, 1978, Oct. 16, vol. 52, no. 20, pp. 113-117.

As a group, hospital trustees have a great potential for effecting positive change in the hospital industry. Hospital administrators and hospital associations must recognize this potential, focus the commitment trustees are willing to make, and put that commitment to constructive use. Without the help of trustees, the process of making positive changes will be difficult, if not impossible.

518. SØNDERGÅRD, W. Brugerrepräsentanters rolle i sygehusbyggeri. **[The role of user representatives in hospital building.]** *Tidsskrift for danske Sygehuse*, København, 1978, Oct., vol. 54, no. 9, pp. 155-158.

A three-day seminar was held involving all groups likely to be involved in the planning and construction of a hospital. User representatives are normally selected on the basis of status rather than function (nine consultants to one nurse and one patient), and nurses are generally under-represented. A user representative must be instructed in the terms employed; be capable of understanding and amending plans; have time, insight and competence to discuss, comment, review and where necessary oppose the ideas presented, and must be prepared to take whatever criticism may be directed towards the finished product. The representative is entitled to demand an introductory course in his tasks; information regarding his terms of reference; a digest of relevant laws and regulations, and the right to make his influence felt. Hospital planning and construction should be steered by as small an advisory group as possible. The group must be able to call on *ad hoc* expert advice, and its activities must be co-ordinated by an overall chairman. User representatives must be appointed on the basis of their knowledge of hospital functions and their utilization of these functions—and not on the basis of seniority. The user representative group must hold frequent follow-up and feed-back meetings with architects and technicians in order to correct mistakes and misunderstandings, assess progress, and gain worthwhile experience which can be used on subsequent occasions.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 487-490, 579, 598

519. GRADE, J. S. and ARANDES, J. H. **Harnessing solar energy for use in hospital buildings.** *Hospital Engineering*, London, 1978, Dec., vol. 32, no. 10, pp. 8-10, 12-13, 15-16.

Solar energy is usually considered competitive with other forms of energy when there is a minimum of 2,000 hours of sunshine per year, at a latitude of less than 45°N. In Portugal, 97.5 per cent of the country is above this value. Portuguese hospital facilities present an extremely favourable geographic position as far as the use of solar energy is concerned. A brief economic study demonstrates that: (i) the use of solar energy is economically feasible, even considering an average life period which is obviously short; and (ii) fuel savings, and therefore foreign currency savings, amount to values between 75 and 80 per cent in the Lisbon area. The constructional features of a practical installation are presented.

520. NEUMANN, B. R., HARMS, D. M. and BLOOMFIELD, D. K. **Consolidation of community hospitals.** *Journal of Community Health*, New York, 1978, vol. 4, no. 1, pp. 73-83.

The largest component of United States health care expenditure is the cost of hospital care. Evidence appears to indicate that community hospital costs can be reduced through the consolidation of some, or even all, hospital services. Although no discernable set of relevant minimal costs for the hospital industry has been established as yet, significant economies of scale can be attributed to the consolidation process.

Medical benefits can also accrue to the community as well when inefficient, low-volume services are combined to provide more attractive resources to highly qualified specialists. Many independent community hospitals operate autonomously, often to the detriment of community health needs and economy. Those hospitals that fail to take advantage of the opportunities offered by consolidation may not be keeping faith with the population they claim to serve.

521. BROOK, R. H., WILLIAMS, K. N. and ROLPH, J. E. **Controlling the use and cost of medical services: the New Mexico Experimental Medical Care Review Organization—a four year case study.** *Medical Care*, Philadelphia, 1978, Sept., vol. 16, no. 9, supplement, pp. 1-76.

This study attempts to assess the effects of peer review on the use of and expenditure on medical services in the New Mexico Medicaid programme over a four-year period. There are chapters on: the review organization; the New Mexico Medicaid population; use and cost of services in the programme; in-patient hospital use in the programme; and summary and conclusions. Careful examination of the findings has led to the conclusion that professional standards review organizations may influence the quality of care but will play little role in containing costs. If expenditure on the peer review approaches the level spent in New Mexico, then three to five billion dollars will be spent on such activities. Given such projections, society must specify clearly how much quality of care needs to be altered to warrant such expenditure. The focus of the PSRO programme should be moved more towards improvements in quality of care and away from containing the costs of care. More fundamental actions by other social agents will be necessary to accomplish the latter.

522. LAMONT, G. X. **Creativity and hospital costs: it's all in the approach.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 93-94, 98, 102, 104.

Although most hospitals do consider costs before deciding to fund a new undertaking, many of them fall short of the necessary inventiveness when it comes to developing low-cost alternatives in problem-solving situations. This paper describes four management technique/cost containment relationships used at New Britain (Conn.) General Hospital to consider cost before deciding to fund a project: the budget development process; the type of surgical case booking system; cyclical staff schedules; and inventory control and materials management. Effective long-range planning must be flexible to provide maximum cost containment benefits. The in-patient census has extraordinary cost containment potential because it directly affects the volume of services, and thus the expenses, of most departments. The in-patient census relates to cost containment in several ways: regulation and control; census forecasting and nursing unit closings; and multimedical specialty, or unspecialized, nursing units.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See Abstract Nos. 520, 560, 602

OFFICE MANAGEMENT AND METHODS

See Abstract No. 571

ELECTRONIC DATA PROCESSING

See Abstract No. 523

LIBRARIES

523. HINMAN, E. J., editor. **Advanced medical systems: the 3rd century; from the eighth annual meeting of the Society for Advanced Medical Systems (SAMS) held in Boston, Massachusetts.** Miami, Fla., Symposia Specialists, 1977, x, 229pp.

The proceedings of the eighth annual meeting of the Society for Advanced Medical Systems examined a number of important issues in health care delivery in the United States. The issues are considered under seven headings. The first section deals with issues concerning the current and future status of health information systems. Section two presents four papers dealing with different aspects of patient involvement in the treatment process. The third section deals with various concerns surrounding health and medical care for the elderly disabled; section four considers specific computer applications and medical records; section five deals with computer applications for planning and certain aspects of systems management, including simulation and development of data management systems for clinical investigators. Section six presents two papers dealing with the development of emergency health systems and section seven presents the report of the task group concerned with systems issues in quality of care assessment and assurance.

524. PHINNEY, E., editor. **The librarian and the patient: an introduction to library services for patients in health care institutions.** Chicago, Ill., American Library Association, 1977, xix, 352pp. $20.00

This book is directed towards developing an understanding of the value of the library and librarianship in the health care setting in the United States. It considers that service to the patient is based on the nature of each individual's needs and that library service to patients should be related to the objectives of the total care scheme of the organization. The 10 chapters consider: inherent values and basic concepts; the health care institution as a setting for library service; the basis upon which services are planned for the patient; planning for library services; the clientele of the patient's library; library resources outside the Institution; library materials for patients; staffing the patient's library; the library considered as a therapeutic environment; and organizing and operating library services to patients. Five appendices consider: a patient's Bill of Rights; public library service to patients; sample contracts and agreements; reader interest classification; and relationship to patients. Each chapter is followed by complete citations of works quoted and additional titles which are included and annotated.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract Nos. 503, 570

MEDICAL RECORDS

See Abstract No. 561

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 603, 612

525. SOUTHWICK, A. F. and SIEDEL, G. J. **The law of hospital and health care administration.** Ann Arbor, Mich., Health Administration Press, 1978, xiv, 500pp.

This book is divided into five parts and considers all aspects of the law relating to the mutual rights and responsibilities of private individuals and institutions in the United States covering contract, tort and property law. The five headings consider: introduction to law and the Anglo-American Legal System; the hospital as a corporation; the physician-patient relationship; the hospital-patient relationship; and the hospital-physician relationship. A table of cases referred to in the text is included.

526. MCCOLLUM, W. E. **Hospital system works to ensure risk management, quality of care.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 86-88.

Samaritan Health Service owns and operates four hospitals in metropolitan Phoenix, manages a rural hospital and an ambulatory clinic, and also owns and operates a hospital-based, fixed-wing air ambulance service. The service conducts a wide variety of institutional and corporate activities and programmes on risk management and quality assurance. Some of these efforts include board review of medical staff organization and privileges, medical and nursing audits, patient care evaluation, a risk manager and steering committee, patient education, equipment maintenance, and safety programmes.

FINANCE AND ACCOUNTING

FINANCE

527. FLOOK, J., DENHAM, T. and NURSE, J. **[Budgeting and costing.]** *Health and Social Service Journal*, London, 1978, Nov. 24, vol. 88, no. 4618, pp. 1341-1342.

The three papers in this series deal with: (i) the development of specialty costing in the North Tees Health District and its use in planning and resource allocation; (ii) the impact of specialty budgeting in the East Cumbria Health District, where it is carried out by a multidisciplinary team; and (iii) the functional budgeting system developed in the West Cumbria Health District.

528. MORREALE, J. C. **The distributional effects of national health insurance in Quebec.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1978, vol. 2, no. 4, pp. 479-507.

In November 1970 a major change in public health policy took place in Quebec: the movement from a mixed private-public system to a completely public system of financing health care (known as Medicare). This policy change has had important economic effects on the distribution of income, taxation, and health care costs. This paper focuses upon the changes in financial burden of medical care costs between

1969-70 and 1971-72 for eight income classes. The key results that emerge are: the total cost of medical care increases sharply for all of the income groups, and the burden of the cost of medical care becomes more equitable across the income groups. Policy considerations for the present debate on national health insurance in the United States are offered.

529. VAN LOON, R. J. **From shared cost to block funding and beyond: the politics of health insurance in Canada.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1978, vol. 2, no. 4, pp. 454-478.

The recent major changes in arrangements between the federal and provincial governments in Canada concerning the sharing of costs for health insurance schemes are outlined. The change from a shared cost (conditional grant) to a modified block funding system was motivated by federal desires to limit and make predictable their expenditures, by provincial desires to increase the flexibility of their allocation of funds and by a mutual desire to limit any growth of health care costs as a proportion of the Gross National Product (GNP). Concerns relating directly to improved medical care were insignificant. The changes will centralize responsibility for financing and delivery of health schemes, thus providing a powerful incentive for provincial governments to apply very strong measures to control costs. However for reasons largely external to the relationship between public sector insurers and the suppliers of medical services, these attempts are likely to be unsuccessful in the short run. The probable impact of this difficulty on the Canadian government and upon members of the health care delivery system is assessed.

COSTS

See Abstract Nos. 522, 598, 604

HOSPITAL ACCOUNTING

See also Abstract No. 527

530. DOSSETTI, G. Gestione ospedaliera aspetti amministrativo-contabili (I). **[Hospital management administrative-accounting aspects. Part I.]** *Tecnica & Metodologia Economale*, Firenze, 1978, Sept./Oct., vol. 17, no. 5, pp. 257-258, 260, 262-267.

The reform of the Italian health system has meant that the resources available to hospitals now consist of a fixed amount for current expenditure, determined by the Provincial and Regional Health Councils, and special funds for investment, also allocated by these Councils. The need for an adequate information and accounting system is therefore urgent. In the first of two articles the author suggests that such a system could be based on an analysis of the structure of hospital costs; it would then be possible to establish regional standards for expenditure. He presents four tables, based on data for Emilio-Romagna, showing what percentage of total current expenditure is devoted to staff, food, drugs, etc., how expenditure in different hospitals deviates from forecast expenditure, and how per capita expenditure on food varies from one hospital to another.

SUPPLIES AND STORES

SUPPLIES

531. DEMONCHY, A. La gestion des approvisionnements à l'hôpital. **[Management of supplies in the hospital.]** *Gestions Hospitalières*, Mantes, 1978, Nov., no. 180, pp. 873-879.

The aim of the supplies department is to make available to the different units in the hospital the correct quantity and quality of supplies at the right time, and within the context of the hospital's general policy, the materials and equipment should be purchased at the best price. Supplies policy reflects general policy which is expressed in its projects, trends, programmes, and budget.

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract No. 543

STORES

See Abstract No. 545

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

532. DEIGNAN, P. B. **Food services merge to contain costs and enhance menu.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 157-158, 160-162.

This paper describes the development of shared catering facilities by St. Luke's Hospital and Charles T. Millar Hospital, St. Paul. The merger was aided by a standardization of menus, which increased the variety to the patient but simplified menu tabulation and production. The shared service has reduced costs, benefitted patients and catering staff, and enhanced the image of many of the hospitals' other programmes.

533. HIDALGO, E. R. Nutrición Clinica: contribucion a la dietetica hospitalaria. **[Clinical nutrition: its contribution to hospital dietetics.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, July/Aug., vol. 2, no. 4, pp. 3-23.

An introduction to the principles and application of nutritional science is followed by an explanation of the role of the dietitian, and then by a detailed description of the department of nutrition at the Puerta de Hierro Clinic in Madrid, which is divided into the food science department, the dietetic department, and the department for the study

of metabolic diseases. Particular attention is devoted to the dietetics department of which there are 26 photographs, as well as a diagram of its functional organization, an administrative chart, a diagram of the hierarchy of the para-medical staff of the department, and a plan of the department. There is also a bibliography with 55 references.

534. SAUCIER, S. J. **Group purchasing of food items maintain quality, cuts costs.** *Hospitals*, Chicago, 1978, Oct. 16, vol. 52, no. 20, pp. 95-96, 98.

HARICOMP, a not-for-profit hospital shared services corporation in Rhode Island, has designed the Computerized Comparative Food Purchasing Program (CFP) to facilitate the group purchasing of food. Member hospitals can now use a cathode ray tube to communicate directly with a computer that carries out price comparison and food ordering for them. This relieves both the catering and purchasing departments of tedious and time-consuming paperwork. The development and operation of the system are outlined and the suppliers' role is discussed. Depending on hospital size, product mix, quality and other considerations, actual savings have ranged from six to 17 per cent of total purchasing cost.

DIETETICS IN THE HOSPITAL

See Abstract No. 533

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

See also Abstract No. 536

535. La nuova lavanderia-guardaroba dell'ospedale civile 'Carlo Poma' a Mantova. **[The new laundry-linen room of the Carlo Poma civil hospital in Mantua.]** *Tecnica Ospedaliera*, Milano, 1978, Nov., vol. 8, no. 11, pp. 46-50.

The new laundry and linen department for the 1,600-bed Carlo Poma hospital was designed by the architect, A. Galdi, in collaboration with the engineers, M. Pavesi and S. Molinari of Mantua. Their purpose was to combine in one building all the services relating to laundry, linen, mattress cleaning, and sterilizing in order to use the water and steam installations in the most efficient way possible, and to automate the washing cycle as far as possible in order to reduce staff costs. The three-storey building comprises: (a) a semi-basement which contains the steam conversion and water treatment installations, and the reception area for sacks and mattresses; (b) the ground floor which is divided into two areas—one for normal and one for infected laundry; and (c) a second floor which contains the linen department, sterilization unit, and ironing area. The description of the building is accompanied by five photographs.

HOSPITAL LINEN AND TEXTILES

See also Abstract No. 535

536. HOLT, J. L. and HENNESSEY, W. J. **System for control monitoring ensures efficient linen use.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 183-184, 186.

Mercy Hospital, Pittsburgh, Pa., has a long-term contract with a co-operative central laundry. In early 1977, the hospital recognized that it was experiencing serious problems because it had inadequate control over three major aspects of the linen programme: (i) total circulating inventory; (ii) internal use of linen; and (iii) daily operation of the linen department. A hospital linen rental firm was asked to study the hospital's linen programme. As a result a linen manager was appointed and three major changes introduced: (i) revision of all areas' daily linen quotas to correlate directly with their daily linen requirements; (ii) change in the linen trolley distribution schedule from night to afternoon; and (iii) implementation of and adherence to a daily linen use policy for all patient care areas. Further steps were: establishment of procedures for ongoing evaluation of the new programme's success and impact and establishment of a new linen committee to review progress monthly. The new programme has reduced linen losses and laundry costs.

HOSPITAL DOMESTIC MANAGEMENT

537. ROBINSON, D. L. and FITCH, K. A. **Customized training program keyed to hospital's procedures, staff.** *Hospitals*, Chicago, 1978, Sept. 16, vol. 52, no. 18, pp. 131-132, 134, 136, 138, 140.

This paper describes a training programme for domestic staff developed at North Carolina Baptist Hospital, Winston-Salem. A set of procedural training materials was developed consisting of co-ordinated 35 mm. colour slides and written scripts. The 13 procedures covered include: routine cleaning of occupied patient rooms; terminal cleaning of isolation rooms; routine care of finished floors; and cleaning of the operating suite and delivery rooms. A demonstration and participative training guide covering each of the basic training sessions was compiled and issued to each of the supervisors who conducted the majority of the one-hour training sessions. Recognition of staff merit and effective supervision and follow-up were additional key elements in the programme, which resulted in decreases in staff turnover and in use of materials.

HYGIENE IN THE HOSPITAL

538. CRESPI GONZALEZ, M. A. La tecnologia de locales limpios en instalaciones hospitalarias. **[Hygiene technology in hospital buildings.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 44-47.

The principles and application of clean room technology are examined with particular reference to vertical and horizontal laminar flow systems. The construction of both types of system, the location of the highly efficient purification air filters, and the

movement of air are discussed, and the relative advantages and disadvantages of each system are examined. Procedures for initial and periodic testing of clean rooms are outlined and, finally, recent trends are summarized.

539. MAURER, I. M. **Hospital hygiene.** 2nd edition. London, Edward Arnold, 1978, xii, 138pp. £3.95

The second edition of this book has been expanded for readers in Australia, New Zealand and South Africa by including details about local standards for sterilizers, local brands of chemical disinfectants and local sources of information. Aspects considered include: hospital infection; sterilization; the best method of disinfection; dust control; cleaning the hospital with water; chemical disinfectants and choice of disinfectants; sterilization and disinfection policy; and hygiene in hospitals.

PREVENTION AND CONTROL

See also Abstract No. 539

540. BARRETT-CONNOR, E. and others., editors. **Epidemiology for the infection control nurse.** St. Louis, C. V. Mosby, 1978, xiv, 322pp. £11.15

This book presents several essays on specific topics in epidemiology which provide a rationale for the knowledge, skills and behavioural patterns of infection control nurses. There are six sections: definitions, methodology and approach; specific infectious diseases; specific problems in the hospital; control measures; administrative and educational aspects; and problem solving exercises.

HYGIENE IN THE OPERATING THEATRE

541. ALLEN, P. and REYNOLDS, D. A. **Clean air operating environments.** *British Journal of Hospital Medicine*, London, 1978, Nov., vol. 20, no. 5, pp. 591-593, 596, 598.

Wound sepsis continues to be a significant cause of post-operative morbidity where surgery involves the implantation of foreign materials into the human body. In this particular field of surgery the importance of air contamination has not yet been fully investigated. New studies have concentrated on clarifying the possible influence on wound sepsis of the environmental air in the operating theatre. Reduction of airborne contaminants can be achieved by several methods: (i) reducing bacterial emission by special clothing that carries away bacteria shed from the body and reduces the heat generated by the body; (ii) improving air filtration by high efficiency particulate air filters; (iii) increasing the air turnover rates around the operating site to achieve maximum positive-pressure flushing effects; and (iv) altering the pattern of air movement so that the air passes in a non-turbulent fashion over the operating site in order to flush potential contaminants away from the wound and not towards it. Methods (iii) and (iv) usually require the patient and operating team to be confined within an operating enclosure. This has led to the present pattern of the ultra-clean room. The principal examples discussed are: the Charnley enclosure; the laminar flow theatre; the air curtain; and the wound isolator.

542. LOWBURY, E. J. L. and LIDWELL, O. M. **Multi-hospital trial on the use of ultraclean air systems in orthopaedic operating rooms to reduce infection: preliminary communication.** *Journal of the Royal Society of Medicine*, London, 1978, Nov., vol. 71, no. 11, pp. 800-806.

This paper describes a study carried out in 15 hospitals in Great Britain and four in Sweden, in which half of their patients who were to have total hip replacement operations were allocated, on a random basis, to ultra-clean-ventilated theatres and half to conventionally-ventilated theatres. The ultra-clean systems involved were five Charnley, three walled laminar downflow, two downflow without walls, three horizontal laminar airflow, three Allander air curtains, and three Trexler ventilated surgical isolators. The hospitals were divided into two categories: sepsis-investigating and sepsis-and-bacteriology-investigating. Information was recorded, usually by a tick or a circle, on five specially designed forms. The trial began in 1975 and at the beginning of 1978, 4,560 operations were included. The last operation to be included will be about the end of July 1979 and it is hoped to make a statement about the effect of ultra clean air on the incidence of infection early in 1981. Preliminary findings show that: (i) all the ultra clean air systems caused a substantial reduction in the number of airborne bacteria and this varied considerably with the different systems; and (ii) bacteria counts in wound washings were lower where ultra-clean air was provided.

543. MITCHELL, N. J. **Disposable clothing in operating theatres, and its effectiveness in reducing aerial microbial contamination.** *NATNews*, Matlock, 1978, Oct., vol. 15, no. 10, pp. 22, 24.

Operating room clothes made in a variety of man-made fabrics can be shown to reduce dissemination of skin bacteria by retaining shed skin particles, while still being comfortable to wear. Dispersal chamber experiments have shown that when unscrubbed male members of the operating theatre staff wear complete sets of clothes made of a non-woven material, bacteria dispersal from the skin is reduced by 72 per cent. When the scrubbed team only wear these clothes, there is no significant reduction. Disposable materials are expensive but for those operations where risks from bacteria are especially hazardous, clothing all staff in a non-woven, disposable fabric produces a safer environment.

STERILIZATION

544. GIBBONS, S. A. **Steam sterilizers.** *Hospital Engineering*, London, 1978, Nov., vol. 32, no. 9, pp. 16-23.

This paper describes the principles and operation of downward displacement and high vacuum sterilizers and of the tests used with them. Thirty-three diagrams and photographs are included.

545. LLOYD, D. S. L. and DUNLOP, A. W. **Stock control in a CSSD.** *British Journal of Clinical Equipment*, London, 1978, Nov., vol. 3, no. 6, pp. 281, 283-284.

The stock control of non-disposable items sent to external hospitals from the central sterile supply department of St. Bartholomew's Hospital is described. The system comprises a special package labelling system and the use of a computer terminal. Each pack has an identification ticket which is amenable to automatic counting and contains a bag for returning the enclosed item. Returned packs are checked for missing items and

the tickets are removed before the items are re-sterilized. The main purpose of the computer programme is to keep a daily record of all returnable items currently stocked at the seven outside hospitals in the scheme. The modular programme deals with the following major functions: (i) returns; (ii) issues; (iii) stock checking; (iv) listing; and (v) recording current data on magnetic tapes. The scheme is efficient in both manpower and computer usage and prevents stock hoarding at the hospitals involved.

AIR HYGIENE

See Abstract Nos. 541, 542

SAFETY MEASURES

546. BLAUM, U. and PFLÜGER, H. Gesundheitsschäden durch moderne Inhalationsnarkotika. Teil 1: Gesungheitsschäden für Patienten und Operationssaal-Personal. **[The effects of modern inhalation anaesthetics. 1. Effects on the health of patients and of operating room staff.]** *Fortchritte der Medizin*, München, 1978, Dec. 1, vol. 96, no. 45, pp. 2269-2272.

This is the first part of a paper on the health hazards of three anaesthetics (halothane, methoxyflurane and enflurane) for patients and operating theatre staff. Because of possible toxic effects on the kidneys methoxyflurane should be used with caution while enflurane is a hazard only for patients who are urological risks: no side-effects on the kidneys have been recorded for halothane. None of the three anaesthetics is known to affect the liver. Observations and experiments on immunoreactions to these anaesthetics are fragmentary and have been very contradictory. The conclusion to be drawn from the results of investigations on the effect of these anaesthetics on pregnancy is that they should be used in the early stages of pregnancy only when it is absolutely essential.

ELECTRICAL ACCIDENTS

547. ROSSI, D. F. M. Seguridad de instalaciones eléctricas. **[Safety of electrical installations.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 30-37.

The main part of this article which considers the effects of electric current on the body and the prevention of electrical accidents when electromedical equipment is used, is devoted to an account of the International Electrotechnical Commission's standards. Five technical appendices are included.

FIRES AND FIRE PREVENTION

548. VAQUE, D. A. S. Adaptacion de centros hospitalarios de Antigua construccion a los nuevos conceptos de la proteccion contra incendios. **[Adapting the building of the hospital centre of Antigua to the new fire protection standards.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, July/Aug., vol. 2, no. 4, pp. 55-63.

This is a practical guide to the implementation of fire regulations in old hospital

buildings. It is suggested that a study be made of the physical characteristics of the building with regard to: (i) fire load, which should not exceed 250 megacalories per square metre; (ii) the length of time (in minutes) that the structural elements will retain sufficient mechanical resistance to maintain the stability of the structure; (iii) the risk of fire spreading from adjacent buildings; (iv) evacuation routes for passages; (v) forced ventilation for stairs and stairwells where there is no natural ventilation; (vi) lifts; (vii) fire spread between floors; and (viii) boiler rooms and electricity substations. This is followed by advice on the positioning of fire alarms, the installation of fire detectors, the preparation of an emergency plan, and the provision of fire extinguishers, hose cupboards, stopcocks, and sprinklers.

THE PATIENT

ADMISSION AND RECEPTION

See Abstract Nos. 595, 609, 615, 619

WELFARE OF THE PATIENT

See also Abstract Nos. 491, 518, 524, 594

549. SHEFFIELD, R. **Community health education fostered by hospital program.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 113-114, 118-119.

The 82-bed Clinton (Mass.) Hospital serves an area with a population of approximately 34,000. It has developed its community outreach programme by offering health care services to schools and industries. The Clinton Hospital Industrial Program offers special first aid courses, testing and rehabilitation services, and staff health plans to the town's numerous small industries. The wide range of services to schools includes the school nurses programme, health education training for teachers, and a cardiopulmonary resuscitation course.

550. LAURANCE, B. M. and LAWRIE, B. **Health and nutrition education unit in a children's hospital.** *British Medical Journal*, London, 1978, Nov. 25, vol. ii, pp. 1469-1471.

The first 18 months of the health and nutrition education unit at the Queen Elizabeth Hospital for Sick Children in an under-privileged area of London's East End is described. The unit is run by a former ward sister and referrals are made by other departments of the hospital and local community health staff. The main areas of health education covered have included accident prevention, correct nutrition, dental care and immunization. About 40 per cent of referrals were concerned with feeding problems and 19 per cent with general child care. Eleven per cent of cases involved accidents and steps were taken to ensure that the accident did not recur. Home visits were made and the unit sister spoke to groups of health workers and to parents waiting in the hospital clinics. Waiting areas were used to display a wide variety of health education literature and home safety equipment. The unit has been welcomed by local health workers and is inexpensive to run.

551. ADAMS, M. A. **Helping the parents of children with malignancy.** *Journal of Pediatrics*, St. Louis, 1978, Nov., vol. 93, no. 5, pp. 734-738.

This paper describes the help given to parents of children with cancer at the Department of Social Work, Memorial Sloan-Kettering Cancer Center, New York. The parents of all children admitted to the hospital are invited to a weekly meeting, led by a social worker. The topics which emerge most frequently include: (i) the parents' feelings towards both treatment of the malignancy and its probable outcome; (ii) the giving of medical information to the parents and advice on how to tell the child about his illness; and (iii) the emotional management of the child, particularly the avoidance of overindulgence. The relationship between parents and their other children and with each other during this time of stress, and ways in which periods of separation may be reduced, are also discussed. Experience shows that these unstructured meetings for all parents, whatever their child's prognosis, play a vital role in resolving problems that arise during this very difficult time.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 580

HOSPITAL SOCIAL WORK

See also Abstract No. 591

552. RENTHE-FINK, B. Die Perspektive für den "Sozialdienst im Krankenhaus". **[Perspectives of social service in the hospital.]** *Das Öffentliche Gesundheitswesen*, Stuttgart, 1978, Nov., vol. 40, no. 11, pp. 734-736.

The hospital social worker, who is trained in the techniques of group work, should have a place in the treatment team. His participation in the therapeutic community (a concept which is slowly gaining ground in Western Germany, chiefly in psychiatric hospitals) is necessary if the whole patient is to be treated. At present social workers in West German hospitals are responsible in some cases to the administrator, in others to the medical director. A report of 1976 proposes that hospital social work should be centrally organized at *Land* level as part of the whole social services system. Social workers in individual hospitals should come under this central body and be independent of the hospital administration department. Berlin would be an ideal *Land* in which to develop a model structure on these lines.

553. MURR, J. M. **Patients and staff favor night ministry program.** *Hospitals*, Chicago, 1978, Sept. 16, vol. 52, no. 18, pp. 72-74.

Local clergy represent a valuable resource for any community hospital. One way in which York (Pa.) Hospital has attempted to make more effective use of clergy is through its night ministry programme. After deciding whom to invite to participate, the hospital's chaplains began to talk personally to each pastor. As a result 28 clergy and two lay women from eight denomination volunteered. Following day-long orientation sessions, night ministry began on 2 May 1977. The programme was set up to cover 200 nights during the year. Week-ends, holidays and 11 weeks during the

summer are covered by staff chaplains and clinical pastoral education students. The night chaplain arrives at the hospital at 2100 and leaves any time after 0600 the next morning. He checks at each nurses' station, intensive care units and the emergency department shortly after 2100 and again at midnight for any patient referrals from physicians or nurses. After visiting all referrals, the chaplain is free to retire for the night. Before he leaves a report is completed. The chaplains have been involved with a wide range of crises.

TRANSPORT OF PATIENTS

554. TINKER, A. J., BIRNBAUM, M. L. and BURNS, L. A. **Mobile critical care unit safeguards lives during transfers.** *Hospitals*, Chicago, 1978, Sept. 16, vol. 52, no. 18, pp. 79-80, 82, 84-85.

The University of Wisconsin Hospitals, Madison, designed a mobile critical care unit (MCCU) which transports critically ill or injured patients from community hospitals to large medical centres. The vehicle selected has front-wheel drive and is supported by a twin-tandem air-suspension system, which allows the vehicle to be lowered within 28 cm of the ground for patient access and affords good stability on the open road. Equipment includes: a volume-cycled ventilator oxygen supply; electro-cardiography monitoring; defibrillation and synchronized cardioversion equipment; radiolucent stretcher bed; 6,000-watt generator; suction, refrigeration and pressure-monitoring facilities; and a transceiver and digital encoder. The vehicle is staffed by a physician and a nurse with critical care training, a medical technologist and an emergency medical technician. Brief details are given of the financing of the unit and of the first 200 patients in it.

TERMINAL CARE

See also Abstract No. 592

555. BRON, B. Tod und Sterben in unserer Zeit. **[Death and dying in our time.]** *Fortschritte der Medizin*, München, 1978, Nov. 9, vol. 96, no. 42. pp. 2150-2154.

As the technology of medicine progresses more and more elderly and sick people are dying in hospital. The problem of dealing with dying people, a task for which doctors and nurses have had no adequate training, becomes increasingly acute. Whether or not to tell the patient the truth, and how to be of assistance to him when he is dying, becomes a problem of communication between doctor and patient which gives rise to emotional conflict for the patient, the doctor and the nurse. Medical and nursing education should include more teaching on this subject.

556. GARFIELD, C. A. **Psychosocial care of the dying patient.** New York & London, McGraw-Hill, 1978, xvii, 430pp. £10.45

This book is described as a definitive resource text, primarily for doctors, on the psychosocial care of the dying patient. It is in eight parts and presents guidelines for: terminal care; patients and families facing life-threatening illness; the emotional impact of doctor-patient relationships; the recognition of psychological needs; counselling the patient's family; recent developments in the care of the dying patient; and various specific issues.

557. KRANT, M. J. **The hospice movement.** *New England Journal of Medicine*, Boston, 1978, Sept. 7, vol. 299, no. 10, pp. 546-549.

Several hospice units, based on the St. Christopher's Hospice in London, are being built or planned in the United States. All provide home-like surroundings and one particular concern is to provide some respite to families caring for a dying relative. Another major concern is the management of distressing symptoms, and meticulous attention is given to the problems of pain. Support to the families of the dying patient is a vital aspect of the hospice's work and one in which volunteers can give valuable help. Hospices also arrange home-care services by integrating various community agencies to provide a 24-hour service. The question of insurance for hospice care and whether it is cheaper than terminal care in hospital still has to be worked out. Hospice care is essentially palliative, but none the less it requires skilled medical management.

558. WARD, B. J. **Hospice home care program.** *Nursing Outlook*, New York, 1978, Oct., vol. 26, no. 10, pp. 646-649.

A hospice home care programme was set up at Overlook Hospital, New Jersey, in January, 1977, and during the first 11 months a total of 3,752 visits were made to 89 patients. To implement the service, members of an expanded existing home care department received training in all aspects of the care of the dying patient and the hospice philosophy. The patient's family physician makes home visits and helps the nurse to plan doses of pain medication. The nurse is the co-ordinator of the team and weekly meetings are held to inform the entire home care staff about all patients. Support and counselling for the patients' families, some of which is done by trained volunteers, is another important aspect of the service. The hospital's pastoral care department provides emotional support and consultation for the staff involved in the hospice programme.

HOSPITAL CARE

See also Abstract Nos. 504-507, 516, 521, 526, 574, 585, 586, 588, 589, 605, 606, 622

559. STRUMPF, G. B., SEUBOLD, F. H. and ARRILL, M. B. **Health Maintenance Organizations, 1971-1977: issues and answers.** *Journal of Community Health*, New York, 1978, vol. 4, no. 1, pp. 33-54.

The promotion of Health Maintenance Organizations (HMOs) as part of a national health strategy, began in 1971 in the United States. An analysis of the data accumulated sheds new light on the issues raised during the legislative hearings prior to the HMO Act of 1973. It describes the developmental process of the HMO scheme and suggests procedural modifications. It illustrates the difficulty of determining HMO viability during the early stages of operation, examines the varied hospital utilization rates of prepaid group practices and individual practice models, and suggests a hypothesis based on the dynamics of group process and peer pressure for HMO provider behaviour.

560. BECK, B. and HARDWICK, K. **Inpatient audit simplified.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 75-78.

The audit programme at Cottonwood Hospital, Murray, Utah, identifies the neces-

sary procedures for selecting criteria, performing audits, and conducting follow-up and shows how they can be accomplished most effectively and efficiently. The way in which the hospital completes the Joint Commission on the Accreditation of Hospitals' audit form sheets is described, as is its use of key sort cards to sort and store the audit data. It is also shown that a useful emergency department/out-patient audit can be conducted using data from telephone follow-up of the patients.

561. FERNOW, L. C. and MCCOLL, I. **Medical audit.** *Journal of the Royal Society of Medicine*, London, 1978, Nov., vol. 71, no. 11, pp. 787-790.

This paper first outlines the informal methods of medical audit in use in the United Kingdom and presents the case for the introduction of more formal systems. It then goes on to discuss developments at Guy's Hospital, London, where the use of problem-orientated medical records (POMR) was introduced in 1974. For a study of the effect of POMR on clerical performance, a method was devised for awarding scores for the clinical management of each patient. A linear multiple regression model was used to express the size of the change in clinical management scores occurring between 1972 and 1975 in each firm. For experimental purposes and to improve the precision of the analysis, 12 patient risk factors (social as well as psychological and constitutional) were part of the basic design of the study. The validity of this method is discussed.

DISCHARGE OF PATIENTS

562. WALLER, J. and others. **Early discharge from hospital for patients with hernia or varicose veins: report of a randomized controlled trial.** London, Her Majesty's Stationery Office, 1978, [iii], 74pp. £1.75

The overall design of this study was that of a randomized controlled trial in which patients were randomly allocated to a 'normal" (six to seven days) or shorter (48 hours) length of hospital stay. The general framework of analysis was that of a cost effectiveness study in which effectiveness was measured by clinical outcome, together with the attitudes of both the patients and health service personnel involved. The method of collecting the data is outlined and the interpretations and service implications of the findings discussed. The economic implications of early discharge were found to depend on the degree to which it was adopted and on whether such a policy was intended to save money or extend services at no extra cost.

HOME CARE, AFTER-CARE

See Abstract Nos. 558, 616

SPECIAL DEPARTMENTS

WARDS

See Abstract No. 498

OPERATING SUITES

See also Abstract Nos. 485, 501, 508, 509, 541, 543, 546, 588

563. LEWIN, W. **The organisation and staffing of operating departments.** *Nursing Times*, London, 1978, Oct. 19, vol. 74, no. 42, pp. 1711-1712.

The Lewin Report on the organization and staffing of operating departments encouraged nurses to specialize in operating department work and made recommendations to that effect. In addition, it recommended the development of senior operating department assistants and operating department assistants with a definite training scheme and career structure. Discussions on the appropriate post-training assessment for the senior grade are still in progress. The training does allow for an operating department assistant to be a scrubbed member of the operating team if necessary, but this in no way threatens the theatre nurse's total responsibility for the patient's welfare. Flexibility should be the key to the report's implementation.

564. PRESTON, B. **An historical perspective.** *Nursing Times*, London, 1978, Oct. 19, vol. 74, no. 42, pp. 1712-1713.

The author outlines the historical background which led to the emergence of operating department assistants in 1973, following the Lewin Report on the organization and staffing of operating departments. This recommended that a new worker should complement the work of theatre nurses, and a City and Guilds training course was established in 1975 to train operating department assistants. These assistants are trained for a wider range of duties than their predecessors, the theatre assistants, and work as colleagues of the theatre nurses, subject to the direction of the senior operating department assistant, or nursing officer in charge of the theatre.

565. SMITH, J. **An ODA is not a nurse.** *Nursing Times*, London, 1978, Oct. 19, vol. 74, no. 42, pp. 1714-1715.

An operating department assistant is not inter-changeable with a nurse, but some duties generally considered to belong to theatre nurses are included in the operating department assistant's training. The training syllabus needs to be more flexible to allow for local needs and to prevent the operating department assistant becoming over-qualified. The system of employing operating department orderlies in the Glasgow area, where there are no assistant training courses, works well, but many would welcome further training without in any way infringing upon the duties of their nursing colleagues. A job description for an operating department assistant, drawn up at the Southern General Hospital, Glasgow, is included.

ANAESTHESIA

566. BAKER, A. B. **Staffing in anaesthesia in Australasia.** *British Journal of Anaethesia*, London, 1978, Nov., vol. 50, no. 11, pp. 1165-1168.

In 1977 a questionnaire on staffing levels was sent to Heads of Departments of Anaesthesia in major teaching hospitals in Australia and New Zealand. The following recommendations with regard to staffing and work load were made: (i) 600 patients

anaesthetized per year per full-time staff equivalent; (ii) four clinic sessions per week per full-time staff equivalent; and (iii) 20 surgical beds per full-time staff equivalent. This allows for time spent in teaching and research by senior staff. When the response to the questionnaire and these recommendations were compared, it appeared that about one third of Australia's Departments of Anaesthesia were staffed reasonably, while two-thirds were under-staffed. It is hoped that the recommendations will help departments to achieve a higher level of staffing and improve job satisfaction.

567. LUCAS, B. G. B. **Are nurses of value in anaesthesia?** *NATNews*, Matlock, 1978, Oct., vol. 15, no. 10, pp. 43, 45.

The first move to introduce nurses into anaesthesia in this country was made in the 1930's. At University College Hospital, London, in the 1940's the anaesthetic nurse became responsible for: (i) the flow of patients to the theatre; (ii) the patient while on the operating table; (iii) teaching other nurses the care of the unconscious patient; (iv) preparing drugs for the anaesthetist; and (v) overall charge of the anaesthetic room and equipment. Anaesthetic nurses are now accepted in many hospitals, and with the expanding of the anaesthetist's work to include out-patients and intensive care therapy, their services will continue to be vital.

PHARMACY

See also Abstract Nos. 594, 612

568. LUCAROTTI, R. L. and FISH, K. H. **Training staff pharmacists for clinical positions.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, Oct., vol. 35, no. 10, pp. 1227-1230.

This paper describes a five-phase education and training programme for establishing and maintaining the clinical competency of pharmacists in the 940-bed William Beaumont Hospital, Royal Oak, Miss.: (i) pharmacists are given selected text book and journal materials in 15 study sections, each requiring 20 to 30 hours of the pharmacist's own time to complete; (ii) they receive two months of instruction in the daily clinical routine with emphasis on applying knowledge by investigating clinical problems through case presentation and by answering questions of health professionals; (iii) they are assigned to a patient care area for two months to perform the duties of a clinical pharmacist; (iv) they are assigned to the drug information centre for two months; and (v) they receive one-year of continuing education consisting of regularly scheduled clinical rounds, meetings and conferences. Upon completion of the first four phases, pharmacists selected for clinical positions provide clinical services for eight to 10 months and rotate to the pharmacy distribution area during the remaining two to four months per year.

569. MCLEOD, D. C. and others. **Use of a pharmacy technologist to manage technicians' activities.** *American Journal of Hospital Pharmacy*, Washington, D.C. 1978, Nov., vol. 35, no. 11, pp. 1393-1394.

The role of a pharmacy technologist, in comparison with that of a pharmacist and a pharmacy technician, is discussed as it was developed at the 680-bed Buffalo (N.Y.) General Hospital. After one year of employment, the technologist was engaged in

training new technicians on-the-job, personnel management for the technicians, and systems management. The hospital staff accepted the technologist, but this only occurred after several years of gradual upgrading of the pharmacist's functions. The technologist was paid a salary equivalent to about 60 per cent that of a staff pharmacist and about 160 per cent that of a technician. The technologist was cost-effective because almost all his duties were previously performed by pharmacists. The implications of the experiment are discussed.

570. DICKSON, W. M. **Measuring pharmacist time use: a note on the use of fixed-interval work sampling.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, Oct., vol. 35, no. 10, pp. 1241-1243.

Pharmacist time use was studied over a three-month period to examine whether fixed-interval work sampling would provide results comparable with those obtained when random-interval observations were used. Four separate measures of pharmacist time use were designated: tasks, duties, competencies and productivity. In every case the fixed-interval method gave an estimate that was not significantly different from the random-interval procedure. The findings suggest that pharmacist work patterns are not sufficiently cyclical to introduce a bias in work sampling by fixed intervals. Fixed interval work sampling yields results comparable with those using the standard work sampling methods that rely upon random time periods between observations.

571. GIBB, S. M. **Typing of out-patient prescription labels—experience with an automated facility.** *Australian Journal of Hospital Pharmacy*, Victoria, 1978, vol. 8, no. 3, pp. 109-111.

The Royal Perth Hospital pharmacy department has long practised the philosophy of using support staff to perform technical, distributive and manipulative functions. A skilled typist is therefore employed to prepare all labels for out-patients' dispensed medicines. An IBM Memory Selectric typewriter is used. With two drugs and 12 labels per track the automated system has a capacity of 100 drugs and 600 labels. As compared with a manual typewriter, the new system has reduced the typographical error rate from 34-48 per cent to nil. A net efficiency gain of some 22 per cent has been achieved if some other elements of the operation are performed at the same time as the typewriter performs automatic elements. The typist's capacity to absorb new work has risen some 20 per cent.

572. HAYMAN, J. N. and others. **Physician use and evaluation of a hospital-based drug information center.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, Oct., vol. 35, no. 10, pp. 1238-1240.

A six-month study at the Medical University of South Carolina Hospital, Charleston, investigated the use of the drug information centre by physicians. A questionnaire was used to gather information from physicians using the services of the centre. Of the 126 questionnaires distributed, 115 (91.1 per cent) were completed and returned. The five categories of drug information most frequently requested involved adverse reactions, dosage, therapeutic use, availability and toxicity. Physicians used information most frequently for purposes of direct patient care. Evaluations of the quality, accuracy and quantity of information provided by the centre were high. Physicians using information for purposes of direct patient care felt that the information was clinically significant. Although certain inadequacies were identified, it was concluded

that the centre serves as a reliable source of comprehensive and accurate drug information for physicians.

573. NELSON, A. A., MEINHOLD, J. M. and HUTCHINSON, R. A. **Changes in physicians' attitudes toward pharmacists as drug information consultants following implementation of clinical pharmaceutical services.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, Oct., vol. 35, no. 10, pp. 1201-1206.

The changes in physicians' perceptions of pharmacists as clinical drug information resources following initiation of routine clinical pharmaceutical services, were studied in the University of Illinois Hospital, Chicago. Data were collected from questionnaires sent to resident physicians and chiefs of services one month prior to the initiation of clinical pharmaceutical services and again one year later. Usable replies were received from 113 (49 per cent) of physicians during the first phase and 125 (53 per cent) during the second phase. In both surveys, physicians rated all six general areas of drug information (literature reports of clinical studies, drug effects on laboratory tests, drug-drug interactions, adverse drug reactions, contra-indications of choice of most appropriate drug) as being of equal concern in patient care. Physicians' assessments of pharmacists' competencies in all six areas improved significantly following implementation of clinical pharmaceutical services. Physicians also reported a significant increase in the use of pharmacists as drug information sources. Pharmacists were assessed as having greater competencies than physicians in the first four areas of drug information, equal competency in the area of contra-indications, and less competency in the ability to choose the most appropriate drug.

574. CARDONI, A. A. and THOMPSON, T. J. **Impact of drug information services on patient care.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1978, Oct., vol. 35, no. 10, pp. 1233-1237.

The use of information provided by the drug information service and its effect on patient care were investigated at the University of Connecticut Health Center, Farmington. All drug information requests received during the period from 1 May to 15 August, 1977, were reviewed and followed up to determine: (i) the usefulness of the information provided; (ii) specific outcome(s) of applying this information to a patient-specific problem; and (iii) the ultimate effect of these outcomes on the patient. A total of 491 requests were received and 443 (90 per cent) of these were followed up. Of those followed up, 421 (95 per cent) were related to patient care. Of the 421 requests related to patient care, 350 (83 per cent) were patient-specific. Of the 350 patient-specific requests, 329 (94 per cent) were judged by the requests to have provided useful information. Of these 329 requests, 202 (58 per cent) resulted in provision of information that affected patients' outcomes, of which 157 (87 per cent) had positive effects on patients. It is concluded that: (i) the drug information centre is providing useful information to health professionals; (ii) the information is being applied to patient-specific problems; and (iii) use of the information is having a positive inpact on patient care.

575. LINKEWICH, J. A. and DI MATTEO, F. P. **A justification of unit dose drug distribution from decentralized units.** *Hospital Pharmacy*, Philadelphia, 1978, Aug., vol. 13, no. 8, pp. 424-426, 428-430.

After some years of discussion and trials of a centralized unit dose programme, the

700-bed Hospital of the University of Pennsylvania decided that a decentralized approach would best suit its needs. A centralized system would be difficult because of the physical configuration of the hospital. The pilot decentralized dispensing operation began in March 1977. The feasibility study lasted six months and compared 100 beds serviced by the traditional system with 100 beds serviced by the unit dose system from a satellite pharmacy. The programme's protocol and dispensing procedures are described. Nine of the reports on the programme generated by the pharmacy department or management services department are summarized in the paper. They show that the system could not be justified solely on the bases of the financial data collected, though some refinements could have demonstrated additional savings in drug costs. Other data not described in the paper were collected and used in justifying adoption of the system described including the professional contribution of the pharmacist, support from the literature, the meeting of accreditation standards, and better basic service.

LABORATORIES

576. CASSCELLS, W., SCHOENBERGER, A. and GRABOYS, T. B. **Interpretation by physicians of clinical laboratory results.** *New England Journal of Medicine*, Boston, Mass., 1978, Nov. 2, vol. 299, no. 18, pp. 999-1001.

As both the number and cost of clinical laboratory tests continue to increase at an accelerating rate, physicians are faced with the task of comprehending and acting on a rising flood tide of information. A small survey was conducted to obtain some idea of how physicians do, in fact, interpret a laboratory result. In this group of students and physicians, formal decision analysis was almost entirely unknown and even commonsense reasoning about the interpretation of laboratory data was uncommon. From these preliminary observations, it is suggested that one contribution to overuse of the clinical laboratory may be the misunderstanding of laboratory data. If so, this would be a remediable problem. Although formal decision analysis may appear too complex to some, practical instruction in the theory of test interpretation is welcomed by most physicians.

BLOOD TRANSFUSION DEPARTMENT

577. WAHEED, A. **A survey about blood bank policies and procedures.** *Transfusion*, Philadelphia, 1978, July/Aug., vol. 18, no. 4, pp. 482-487.

A questionnaire about blood bank policies and procedures was sent to 170 hospitals throughout the United States; 50 per cent replied. The results are summarized in three tables. They tend to indicate that there is a wide variation in policies and procedures. Some of the variations could be attributed to the differences in style, work load and area of specialization. In general, it seems that blood banks could be grouped into two distinct categories: one tending to be rather cautious in its approach, the other to be rather liberal.

578. RUTMAN, R., BRAY, J. and MILLER, W. V. **Utilization of nursing teams in the collection of blood.** *Transfusion*, Philadelphia, 1978, July/Aug., vol. 18, no. 4, pp. 454-457.

A study to identify the causes of operational problems in blood collection in the

Connecticut Red Cross Blood Center and the Missouri-Illinois Regional Red Cross Blood Program confirmed the original assumption that the problems were due to random assignment to collecting teams and lack of group cohesion. As a result team assignment was implemented in both programmes. The initial strong resistance from nursing staff decreased and in many instances resolved after experience in working with a team. Personnel have not posed problems since the head nurse began emphasizing group responsibility and quality of care. Staff may request a transfer to another team, although this has not yet happened.

579. ROUAULT, C. and GRUENHAGEN, J. **Reorganization of blood ordering practices.** *Transfusion*, Philadelphia, 1978, July/Aug., vol. 18, no. 4, pp. 448-453.

A three-month review at the Los Angeles County-University of Southern California Medical Center revealed that excessive ordering of blood was occurring in some elective surgical procedures. Such procedures as cholecystectomies and inguinal hernia repairs rarely if ever required transfusion. Cross-matches for these and other procedures could clearly be eliminated without risk to the patient. To satisfy the occasional need for blood and to allay the fears of the surgical staff, the type and screen (T & S) procedure was instituted. This consists of ABO and Rho(D) typing and testing the serum for unexpected antibodies by standard techniques. Using the data obtained in the three-month study, a list of surgical procedures was prepared with recommended orders for the number of units of blood to be cross-matched. When a patient enters the hospital for surgery, a T & S is requested. If antibodies are detected, they are identified as soon as possible and an appropriate amount of blood is cross-matched for the patient. If a patient who has no antibodies detected subsequently needs a transfusion, the usual cross-match procedures are followed if there is time. If not, type specific blood is issued and while it is on its way, the ABO and Rho(D) typing is repeated and the cross-match proceeded with. Within six months of the implementation of T & S, the total number of cross-matches performed decreased by 32 per cent, resulting in substantial savings in staff time, reagents and outdating of units of blood.

580. OBORNE, D. J., BRADLEY, S. and LLOYD-GRIFFITHS, M. **The anatomy of a volunteer blood donation system.** *Tranfusion*, Philadelphia, 1978, July/Aug., vol. 18, No. 4, pp. 458-465.

In a study of the motivational aspects of blood donation, self-report questionnaires were sent to 450 current donors, 500 ex-donors and 500 non-donors, matched for sex and area of residence, in the area of Swansea, South Wales. The replies indicate that the motivations to become and remain a blood donor are by no means simple and clear cut. However, they substantiate and extend the results obtained from other studies. Donation is largely a humanitarian act, whereas non-donation arises largely through fears of pain and, perhaps, of the unknown. Of particular interest, however, is the importance attached by non-donors to the reason 'sessions held at inconvenient times'. The majority of ex-donors considered medical conditions precluded them from further donation. Moving away was also frequently reported as the reason for becoming an ex-donor. The results are used to develop a model of blood donor behaviour (reproduced in diagrammatic form and discussed) from which certain predictions of donor behaviour could be made.

REHABILITATION

581. PASTRANA, D. R. Organizacion y funcionamiento de un servicio centralizado de rehabilitacion en un hospital general. **[Organization and administration of a central rehabilitation service in a general hospital.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 48-52.

The functions of the hospital's rehabilitation department are outlined. It is estimated that in a 1,000-bed hospital approximately 200 in-patients and 300 out-patients will require rehabilitative therapy at any one time. The staff will therefore include 12 doctors, 35 physiotherapists, seven occupational therapists, four speech therapists, nine other paramedical staff, and 31 non-medical staff. The unit will require an area of at least 2,050 square metres and will include a gymnasium and swimming pool. The equipment required in each section of the department (general clinic, cardio-respiratory, neurosurgical and injuries clinic, electrodiagnostic and electro-myography room, speech therapy, psychology and psychotherapy room, prosthesis section, children's section, and occupational therapy section) is listed and the work of each briefly outlined.

582. HATSUYAMA, Y. **National programme of prosthetics and orthotics in Japan.** *Prosthetics and Orthotics International*, Hellerup, 1978, Dec., vol. 2, no. 3, pp. 121-124.

This paper outlines the development of prosthetics and othotics in Japan, with particular reference to the national associations; government activity; the number of physically handicapped; problems of qualifications of prosthetists and orthotists; standardization of prosthetic and orthotic appliances; establishment of limb fitting centres; and development of prosthetic and orthotic appliances.

PHYSIOTHERAPY DEPARTMENT

583. DE JERSEY, M. and DALLY, P. **Physiotherapy.** *Medical Journal of Australia*, Glebe, 1978, Aug. 12, vol. ii, pp. 147, 149-150.

This article gives a broad outline of physiotherapy education in Australia and discusses the contribution of the physiotherapist to the health care team. There are five schools of physiotherapy in Australia—one in every state except Tasmania. In 1974 there were 4,439 registered physiotherapists of whom 2,365 were employed; 40 per cent were in hospitals and 30 per cent in private practice, with others in rehabilitation centres, industry and special schools. Physiotherapy management may be divided into two categories: (i) treatment directed towards restoration of function; and (ii) preventive and advisory physiotherapy, where the prevention of disease is increasing. While the role of the physiotherapist will continue to be mainly creative, this spread of physiotherapy into the area of preventive medicine has led to a closer co-operation with the medical profession.

DEPARTMENTS FOR SPECIAL THERAPY

See Abstract Nos. 600, 607, 617

INTENSIVE CARE UNITS

584. BENITEZ, D. M. E. Los servicios de medicina intensiva en el hospital moderno. **[Intensive care services in the modern hospital.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 27-29.

Since the Intensive Care Unit (ICU) forms the basic element in any system of graduated care, the creation of an ICU in all general hospitals from provincial level upwards is recommended. The unit should comprise five to 10 per cent of all beds in the hospital and should be closely linked to all the clinical units, in particular the post-operative recovery unit and the cardiology and cardiac surgery departments.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 571, 590

585. STAMPS, P. L. **Ambulatory care systems. Volume III. Evaluation of out-patient facilities.** Lexington, Mass., Lexington Books, 1978, xviii, 251pp. £14.00

This volume forms part of a set of five books which cover various aspects of out-patient services. The aspects considered in this book are primarily concerned with the quality of health care, the standards and the methods for evaluating health care. There are seven chapters and the aspects considered include: evaluation of ambulatory care; patient satisfaction; satisfaction of direct care providers; quality of medical care; medical audit methods and techniques; and applications of industrial quality control systems to the evaluation of ambulatory care. Two appendices are included: the procedure for scoring the measurement scale for assessing levels of satisfaction of health care providers; and a case study of a medical audit technique for assessing the adequacy of a uniform data base.

586. JONAS, S. **Quality control of ambulatory care: a task for health departments.** New York, Springer Publishing Co., 1977, xiii, 178pp. $12.50

This book examines the problems of the provision of ambulatory care in the United States. It raises the question of the impact of national health insurance on ambulatory care and examines examples of government-funded ambulatory care schemes in New York State as prototypes of how the government can provide subsidies and at the same time control expense and quality. Ten appendices are included presenting evaluation reports on ambulatory care systems and the hospital codes and legislation relevant to New York State.

587. KONCEL, J. A. **Ambulatory surgical center lowers costs, not services.** *Hospitals*, Chicago, 1978, Oct. 16, vol. 52, no. 20, pp. 101-102, 104.

This paper describes the development of the Florence and Everett McDonnell Surgical Center as an ambulatory surgical facility at Piedmont Hospital, Atlanta, Ga. Although attached to the hospital, it is a separate building in appearance. To

accommodate emergencies, a lift at the back of the building leads directly to the hospital's surgical department. At present about six to nine procedures a day are performed in the centre, which does its own scheduling. The staff includes a head nurse, two recovery room nurses, a surgical aide, a surgical nursing assistant, a maid and a secretary who is a hospital volunteer. Depending on the need for their services, one or two operating theatre technicians and one or two circulating nurses from the hospital's main surgical suite work daily in the centre.

CASUALTY AND ACCIDENT

See also Abstract Nos. 486, 510, 554, 560, 618, 619

588. FISCHER, R. P., JELENSE, S. and PERRY, J. F. **Direct transfer to operating room improves care of trauma patients: a simple, economically feasible plan for large hospitals.** *Journal of the American Medical Association*, Chicago, 1978, Oct. 13, vol. 240, no. 16, pp. 1731-1732.

At the St. Paul-Ramsey Hospital, St. Paul, Minnesota, seriously injured patients are resuscitated and examined in the operating theatre. Often more than one theatre is used as a trauma receiving room. The equipment permits detailed examinations to be carried out and nursing support is provided by the operating theatre staff. One third of the emergency patients received in the operating theatre undergo major operations and 57 per cent receive minor operative procedures. The system has improved emergency patient care and has reduced staff costs in the accident and emergency department without increasing those in the operating department.

589. BRODSKY, L., ANWAR, R. A. H. and DIANGI, S. **Extension of emergency medical care: continuing emergency care clinic.** *Journal of the American College of Emergency Physicians*, Lansing, 1978, Oct., vol. 7, no. 10, pp. 358-360.

A Continuing Emergency Care Clinic (CEC) was set up at the Medical College of Pennsylvania in an attempt to increase emergency department patients' compliance with follow-up appointments. A total of 375 emergency department patients given appointments to the CEC were studied. The majority of patients understood why they had to return for follow-up and were satisfied with the service of both the emergency department and the CEC. Once patients had entered the CEC system, the level of compliance was consistently high. The CEC structure ensured that the patient was attended by the same doctor as attended him in the emergency department, and this continuity was the major factor in improving patient compliance.

590. PEDERSEN, H., PEDERSEN, J. and MEINERTZ, H. Hvad laver sygeplejerskerne på skadestue og modtagelse: hver akut patient giver sygeplejersken ca. 8 telefonopkald. **[The work of the nurses in the casualty reception unit of the County Hospital, Glostrup: about eight telephone calls are required for every emergency patient.]** *Sygeplejersken*, København, 1978, Nov. 8, no. 44, pp. 12-18.

The Casualty Department at Copenhagen County Hospital, Glostrup, is one of the busiest in the country, treating some 50,000 cases a year as against the 20,000 it was planned for 25 years ago. The largest category of patients are people suffering from accidents at work, followed by children from schools, crèches etc. The chronically

sick represent a group which comes back again and again, since it is easier to go to hospital than phone and wait for a doctor. Chronic abusers of drugs, alcohol and medicine are frequent visitors, occupying a great deal of staff time. Burns and acute poisoning cases, whether accidental or suicidal, are referred to other hospitals after the initial treatment. The number of traffic cases has declined since the introduction of low speed limits and compulsory seat belts and crash helmets. Day staff consists of a sister, two nurses, three students or auxiliaries, a secretary and two porters: staff is reduced to two nurses and two auxiliaries in the evening, and one of each at night. From 7.30 to 10.30 am the department processes all patients who have called in for consultation at the hospital—some 60 cases a day. Surgical cases arrive first (7.30 to 8 am), and medical cases from 9.30 am onwards. The nurses are happy in their work, but nevertheless are worried about the inadequacy of treatment and long waiting times. The article is illustrated with a dozen or so interior photographs of the department in action.

OCCUPATIONAL HEALTH

See Abstract No. 546

DAY HOSPITALS

See also Abstract Nos. 597, 620

591. PEACH, H. and PATHY, M. S. **Social support of patients attending a geriatric day hospital.** *Journal of Epidemiology and Community Health*, London, 1978, Sept., vol. 32, no. 3, pp. 215-218.

A longitudinal survey of the social support of patients attending St. David's Geriatric Day Hospital, Cardiff, confirmed an impression that support was not being adjusted to meet the changing degrees of dependency among the patients. An experimental study, in which the social support available to a small group of consecutive new admissions was reduced, showed that their dependency scores were not significantly different from those of a control group which continued to receive support. The significance of this finding in reducing the cost of day hospital care is discussed.

CHILDREN

See also Abstract Nos. 480, 550, 551

592. BLUEBOND-LANGNER, M. **The private worlds of dying children.** Princeton, N.J., Princeton University Press, 1978, xv, 283pp. £8.40

The behaviour of children suffering from leukaemia and aged between three to nine years old was studied in the paediatric ward of a large mid-western teaching hospital in the United States. The author describes the complex social relationships that were formed and suggests more fruitful ways of relating to dying children as well as adding to the knowledge of the ritual behaviour surrounding death.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 473, 591, 621

593. WILKIN, D. and JOLLEY, D. J. **Mental and physical impairment in the elderly in hospital and residential care 1.** *Nursing Times*, London, 1978, Oct. 19, vol. 74, no. 42, occasional paper, pp. 117-120.

This paper describes a survey of elderly people in hospital and residential care in South Manchester, an area of well-developed geriatric services. Old people, all over 75, in two long-stay geriatric wards, one long-stay psycho-geriatric ward and in 14 local authority homes were assessed during 1977 using the Crichton Royal Behavioural Rating Scale. Each patient or resident was assessed on mobility, orientation, communication, co-operation, restlessness, dressing, feeding and continence. The largest number of mentally and physically impaired individuals was found in the long-stay wards, but there was a significant number in residential homes. There were differences between individual homes in the proportion of impaired residents, and these differences were not always reflected in the grades given to the homes by the local authority's social services department.

594. BAXENDALE, C., GOURLEY, M. and GIBSON, I. I. J. M. **A self-medication retraining programme.** *British Medical Journal*, London, 1978, Nov. 4, vol. ii, pp. 1278-1279.

A patient's self-medication programme has been established in the geriatric assessment unit of the Southern General Hospital, Glasgow. The patient is included in the programme two weeks before discharge and, under close supervision, holds his own drugs and takes them at times suited to a home routine. The degree of supervision decreases as the day of discharge approaches. A district nurse follows up patients after discharge and the local pharmacist and the patient's general practitioner are told that the patient has been trained in taking his drugs. Sometimes a short period of re-training is required.

595. STOUT, R. W., HOBSON, L. A. and WALMSLEY, A. E. **Emergency admissions to a geriatric medical unit.** *Ulster Medical Journal*, Belfast, 1978, vol. 47, no. 2, pp. 109-113.

In December 1976, Belfast City Hospital started to make direct admissions from the casualty department to the geriatric medical unit of patients over the age of 75 requiring emergency medical admission. This paper describes the results of the first year's working of this system. There were 128 emergency admissions via the casualty department; in the same year 424 patients were admitted direct from home or transferred from other wards or hospitals. Tables show the fate of these patients, the most common diagnoses, and state and length of stay in relation to diagnosis. The majority of emergency patients are able to return home again, but there is a fairly high mortality. However, the proportion of patients requiring continuing hospital care for a prolonged period is small. Since the scheme was introduced, requests for transfer from other medical wards have been negligible.

596. DAVIES, V. **Finding the best home for the confused elderly.** *Nursing Mirror*, Sutton, Surrey, 1978, Oct. 26, vol. 147, no. 17, pp. 51-53.

A small psycho-geriatric assessment unit was established in Denbigh, North Wales, in 1974 to help general practitioners with the problems of diagnosis and suitable placement. The unit has six beds and the team includes two psychiatrists, a geriatrician, ward doctor, social workers, therapists and nursing staff. Patients receive a comprehensive assessment of their physical, psychological and social needs during a stay of between two and six weeks. The future care of the patient is decided by the team and the relatives together. Full records are kept and each patient is followed up. Admissions have risen each year. Good communications with general practitioners, the psychiatric social worker and the local authority social services department are vital to the unit's successful functioning.

CANCER

See also Abstract No. 551

597. TIBONE, D. Proposta per un 'day hospital' oncologico. **[Proposals for a cancer day hospital.]** *Tecnica Ospedaliera*, Milano, 1978, Sept., vol. 8, no. 9, pp. 21-30.

This extract from a student's degree thesis presents a design for a cancer day hospital, to be constructed in the grounds of an existing hospital. The economic, medical, and psychological benefits of day hospital treatment are analyzed. This design is for a two-storey unit with a semi-basement, built around a central courtyard in a landscaped setting. The facilities would include an operating theatre and ancillary area, six four-bedded rooms, a large general waiting room, cafeteria, bar, film theatre, games room, shop, medical library, and records department. The description is accompanied by seven diagrams.

CARDIOLOGY

598. STONEY, W. S. and others **The cost of coronary bypass procedures.** *Journal of the American Medical Association*, Chicago, 1978, Nov. 17, vol. 240, no. 21, pp. 2278-2281.

The hospital's financial records of 200 patients who had coronary bypass surgery at St. Thomas Hospital, Nashville, Tenn. in 1976, were examined and the hospital and physician costs determined. The average hospital bill was $7,694 and the average length of stay was 18 days. The average physician charge to the patient was $3,240, making an average total cost of $10,930. The average costs increased by 59 per cent between 1971 and 1977. Coronary bypass operations are increasing in frequency and cost, and as the use of many hospitals, supportive services are needed, there is little prospect of these costs being reduced.

ORTHOPAEDICS

See also Abstract Nos. 542, 582

599. KRIEGER, W. **Reflections on training in orthopaedic techniques.** *Prosthetics and Orthotics International*, Hellerup, 1978, Dec., vol. 2, no. 3, pp. 118-120.

This paper discusses, with particular reference to the Federal Republic of Germany,

the training of those staff who are needed for medico-technical measures within the framework of rehabilitation of the physically handicapped and disabled. Three questions are of paramount importance: (i) the type of staff required; (ii) the number of staff required; and (iii) how they should be trained. Two groups of staff are required: (i) skilled personnel exclusively or predominantly employed in the workshop area; and (ii) the most highly-qualified personnel who bear the responsibility for measurement, preparation and fitting of aids, instruction and training as part of treatment, and supervision of the workshop staff. About one orthopaedic worker per 100 physically disabled and handicapped patients is required; about 15 to 20 per cent should be in the top grade. Some problems of organizing appropriate training schemes are outlined. The nature of such programmes, particularly their levels, will probably be determined by the peculiarities of individual national education systems.

UROLOGY

600. ROBINSON, B. H. B., editor. **Dialysis, transplantation, nephrology: proceedings of the fourteenth congress of the European Dialysis and Transplant Association, held in Helsinki, Finland, 1977.** Associate editors: J. B. Hawkins [and] P. Vereerstraeten. Tunbridge Wells, Pitman Medical 1977, [xiv], 661pp. £18.00

This volume is the record of the scientific papers of the 14th Congress of the European Dialysis and Transplant Association held in Helsinki in 1977. Areas of interest considered in the Congress include: statistical reports on dialysis and transplantation in Europe; dialysis—haemodiafiltration, ultrafiltration, anaemia and general aspects; scientific forum on prospects for specific immuno-suppression; transplantation—graft prognosis, graft rejection, graft monitoring and complications; nephrology—renal osteodystrophy; clinical nephrology, renal pathology and general aspects of nephrology; and posters. A list of the membership of the European Dialysis and Transplant Association is included.

SURGERY

See also Abstract Nos. 562, 587, 598

601. ROSS, J. A. **The Edinburgh School of Surgery after Lister.** Edinburgh & London, Churchill Livingstone, 1978, x, 220pp. £7.00

This book is an account of the achievements of the surgeons at the Edinburgh School of Surgery, between 1790 and 1939. It gives an indication of the effects of Lord Lister's discoveries on antiseptics and traces his influence on the work carried out at the School of Surgery. The development of experimental and scientific surgery and the rise of the various specialties is outlined together with a comparison of the work of Sir John Wilkie and Sir John Fraser.

602. BURGESS, C. and BESCHI, J. **Elective surgery and a programmed investigation unit in a five day ward.** *Hospital & Health Services Review*, London, 1978, Dec., vol. 74, no. 12, pp. 427-428.

In 1975 the Royal South Hants Hospital arranged one ward as a five day ward for both surgical and programmed investigation unit patients. The type of investigation

carried out varies from simple specimen collection to more complex procedures for example, renal biopsies. The length of stay for both types of patient is easy to predict. In the unit's first year 173 patients were admitted for investigation, staying on average two days, and 702 were admitted for surgery, staying on average three days. The five day ward can deal with a wide variety of cases and the combination of surgery and programmed investigation results in a fairly smooth distribution of work.

603. DIXON, E. **The legal aspects of surgery.** *NATNews*, Matlock, 1978, Nov., vol. 15, no. 11, pp. 12-14, 16, 18-20.

This paper presents the findings of a project designed to ascertain the views of a sample of doctors and nurses involved in the care of surgical patients and to assess the reaction of a proportion of the public to doctors and nurses in general, and litigation in particular. Data were collected by means of questionnaires (reproduced) completed by doctors, nurses and theatre students, and structured interviews with members of the general public. The data collected suggest that doctors and nurses involved in the care of surgical patients give a reasonable standard of care, despite the inadequacies of the system. Confusion exists at all levels regarding the legal responsibility to the patient and there is a need for clarification in this area for all grades of staff. The public are better informed and consequently more apprehensive about having an operation. Cases of litigation are increasing although, as yet, they have not reached the same proportion as in the United States. This situation may be avoided if steps are taken now to rectify the position.

MATERNITY

604. HEIN, H. A. **The cost of maternity care in rural hospitals.** *Journal of the American Medical Association*, Chicago, 1978, Nov. 3, vol. 240, no. 19, pp. 2051-2052.

A questionnaire sent to rural hospitals in Iowa revealed that obstetric services are less expensive in small hospitals and that low occupancy figures are not associated with increased patient costs. If the federal recommendation of a minimum figure of 500 deliveries per year were implemented, 81 per cent of Iowa's hospitals with maternity departments would be affected. Rather than enforcing large-scale centralization, health planners should develop regional systems of perinatal care as a means of containing obstetric costs.

605. BRANT, H. A. **The quality of prenatal care.** *Midwives Chronicle*, London, 1978, Nov., vol. 91, no. 1,090, pp. 315-318.

A comprehensive patient programme of obstetric care has been carried out at University College Hospital, London, for many years. It includes classes in ante-natal education and aims to increase patient participation in current medical advances. The assessment of risk forms the basis of obstetric management. These risks may be chronic, including maternal factors and maternal disease, or acute, arising at the end of a pregnancy or during labour. Management aspects which affect the welfare of the foetus and infant include: (i) establishing maturity before inducing delivery; (ii) early induction of labour where necessary; (iii) the care of small-for-dates and pre-

mature babies; (iv) prevention of premature birth; (v) treatment of rhesus incompatibility problems; and (vi) maternal nutrition. Planned screening techniques in ante-natal care aim to reduce risk and the use of selective termination can reduce the number of children born with serious defects. Greater linkage is needed between pregnancy and labour records and the developmental history of the child if care is to be improved still further.

606. HEIN, H. A. **The quality of perinatal care in small rural hospitals.** *Journal of the American Medical Association*, Chicago, 1978, Nov. 3, vol. 240, no. 19, pp. 2070-2072.

The author examines the quality of perinatal care in Iowa, which provides maternity care for 42,000 patients per year in 135 hospitals, 82 per cent of which deliver fewer than 500 babies a year. Owing to a high quality regional perinatal system and a scheme of referring high-risk mothers to larger maternity services, the neonatal mortality rate at these smaller hospitals is less than the average for the State of Iowa. Thus, smaller obstetric services within a regional system can offer acceptable care to relatively low-risk patients.

607. CASARES AVILA, D. A. and QUERO JIMENEZ, D. J. Las unidades de hospitalición neonatológica en el hospital infantil. **[Perinatal care units in the children's hospital.]** *Revista de Hospitales del Instituto Nacional de Previsión*, Madrid, 1978, vol. 2, no. 2, pp. 59-65.

Factors which should be taken into account when determining the size and design of a neonatal unit in a children's hospital include: the type of infant requiring treatment (premature or term); the need for full-time monitoring; the amount of monitoring equipment; the dangers of cross-infection; and the need for comfortable working conditions for the highly qualified staff. A detailed description of a good neonatal unit follows. This is based on the assumption that 84 beds will be required and 12 of these will be for infants requiring intensive care. Descriptions of the intensive care unit, the intermediate and minimal care unit, the nurses' working area, the service area, and the support area are illustrated with a series of 15 diagrams.

OPTHALMOLOGY

608. BORG, G. Dagligliv på et plejehjem for blinde of svagsynede, Solgavehjemmet i Valby: beboerne kender hinanden og personalet alene på gangen. **[Everyday life at the Solgave Home for the blind and partially-sighed, Valby; the residents recognize each other and the staff by their footsteps alone.]** *Sygeplejersken*, København, 1978, Nov. 29, no. 47, pp. 4-9.

The Solgave Home was opened in 1961 on the proceeds of nationwide voluntary contributions as a home for the wholly or partially blind unable to manage at home. The two-storey building comprises 86 single rooms, with communicating doors for married couples. There are facilities for meals, baths, physiotherapy, ergotherapy, hairdressing and chiropody. Two doctors visit all patients twice a week and then confer with all staff in Matron's office. Individual rooms are decorated and furnished so that items feel and sound different, according to function. There are very few carpets,

and everyone wears hard-soled shoes so as to be audible and recognizable at a distance. There are hand rails along all walls (plastic downstairs, brass upstairs), and staff must ensure that nothing is ever left in the way along the walls. In the same way, the scented plants outside are kept pruned back to avoid the risk of people walking into overhanging branches. Staff have to be constantly on the watch for open doors, forgotten pipes or burning cigarettes, and unobserved skin conditions, and have to ensure that medicines have been taken. Patients receive free tape recordings from the National Braille Institute, and a twice weekly news and current affairs tape. The article is illustrated with 17 interior photographs and one exterior one.

DENTISTRY

609. POGREL, M. A. **Why are patients referred to a hospital dental department?** *Health Bulletin*, Edinburgh, 1978, Nov., vol. 36, no. 6, pp. 294-299.

A study was made of referrals from general dental practitioners to the Dental Department at Aberdeen Royal Infirmary from March to May 1975 inclusive. During this period 515 patients were referred, including 67 by doctors and 335 by general dental practitioners. The categories in which these referrals occurred included oral medicine and surgery, periodontology and prosthetics. The most common reasons given were: (i) that a second opinion was sought; (ii) that the procedure involved was too complex to be performed in a dental surgery; and (iii) that the patient wanted a general anaesthetic. Analysis revealed that a proportion of both groups (ii) and (iii) could have been treated by a general dental practitioner, thus saving health service costs. The survey showed there was little mis-use of the hospital dental service in the Grampian area, but if better remunerated, dentists might be prepared to learn and apply the more complex techniques of oral surgery.

PSYCHIATRY

610. RUMER, R. **Community mental health centers: politics and therapy.** *Journal of Health, Politics, Policy and Law*, Durham, N.C., 1978, vol. 2, no. 4, pp. 531-559.

The development of theory and public awareness of mental health from 1900 to 1960 is traced with particular emphasis on the rise of social psychiatric models and the impact of events in and around the Second World War. The federal legislative history of the Community Mental Health Center (CMHC) Scheme in 1976 is outlined with regard to particular social schemes (e.g. alcoholism) and to domestic policies as they affected the scheme's policies and mandates. The poor administration, lack of community control, poor evaluation and accountability of the CMHC Scheme is discussed. The need for an egalitarian approach to policy-making and the use of an explicitly political conceptual framework is outlined.

611. SPÄTE, H. F. and FÜRLE, A. Zur Geschichte der psychiatrischen Versorgung. **[On the history of psychiatric care.]** *Zeitschrift für die gesamte Hygiene und ihre Grenzgebiete*, Berlin, 1978, Nov., vol. 24, no. 11, pp. 876-881.

The development of psychiatric care in what is now the German Democratic Republic (Eastern Germany) is outlined with special reference to the psychiatric

hospital at Bernburg which dates from 1875. From being centres for the isolation and custodial care of mental patients these institutions have become hospitals for active treatment and rehabilitation. In the case of Bernburg there was an intermediate phase when, under Hitler, it was used as a centre for gassing the mentally ill as well as political prisoners. Modern mental health services in Eastern Germany include in-patient and out-patient treatment as well as intermediate stages such as day or night hospitals, sheltered homes, psychiatric nursing homes, and sheltered workshops.

612. GALLANT, D. M. and FORCE, R., editors. **Legal and ethical issues in human research and treatment: psychopharmacologic considerations.** New York & London, SP Medical and Scientific Books, 1978, [xviii], 186pp. £10.50

This book, through discussions involving the interplay of science, philosophy and law, attempts to construct a projection of what lies ahead for neuropsychopharmacologic research and treatment. It attempts to offer ethical and legal directions for research and treatment, particularly for those efforts in psychiatric drug research, for maintaining the primary ethical values of the physician-scientist and his patient-subject without seriously hampering the acquisition of scientific knowledge. The six essays consider: the principles of ethical conduct for neuropsychopharmacologic research in human subjects; the history and future of litigation in psychopharmacologic research treatment; research and the law; barriers and progress; ethical issues in psychopharmacologic research; ethical issues in psychopharmacologic treatment; and recommendations.

613. BACHRACH, L. L. **A conceptual approach to deinstitutionalization.** *Hospital & Community Psychiatry*, Washington, D.C., 1978, Sept., vol. 29, no. 9, pp. 573-578.

The decrease in the numbers of the mentally ill in institutions must be accompanied be an increase in community-based facilities for a variety of patient types. The range of functions performed by hospitals for the mentally ill is very complex and any attempt to provide all these services in the community has met with many problems. Often treatment with drugs has been carried out at the expense of attention to material and personal needs. The aim of rehabilitation should be to return to the patient the skills he needs to live in the community. In some areas it may be difficult to replace the hospital completely, and here it should be incorporated into a unified system of mental health care through the development of new programmes.

614. ANDERSSON, B. and STRAND, B. Rapport om Nackaprojeketet: minskad slutenvård ökad kontinuitet. **[Report on the Nacka project (experiments in sectionalized psychiatric services in the Nacka and Värmdö municipalities of Stockholm County): reduced institutional care and increased continuity in community care.]** *Landstingens Tidskrift*, Stockholm, 1978, Nov., vol. 65, no. 20, pp. 16-19.

The Nacka Project started in 1974, comprising two reception centres in Nacka and one on the island of Värmädo, with a total population of 70,000. The team consists of 13 people (three office staff and 10 therapists), allowing it to remain effective when even as many as five members are off duty, sick or on holiday. The aim of the project is to offer a satisfactory alternative to institutional psychiatric care by means of: (i) round-the-clock availability of a qualified mental advisory service; (ii) mental health consultation facilities; and (iii) preventive activities. These latter

are directed towards the "at risk" groups in the community: (i) people undergoing acute stresses; (ii) primaparae; (iii) isolated mothers of small children; (iv) immigrants; and (v) people afraid of the authorities. The numbers of out-patient consultations tripled during the first year of the trials, compared with a six per cent increase in the rest of the county. At the same time there was a significant drop (32 per cent) in committals to mental and alcoholics institutions. Experimental application of more open psychiatric care in the two municipalities has thus resulted in reduced institutionalization, improved continuity of treatment, earlier intervention and an improved local service at reduced expense. The article is illustrated with a map of the area, comparative tables of the various categories treated before and during the experiment, and a detailed cost analysis.

615. SHAEFFER, D. E., SCHULBERG, H. C. and BOARD, G. **Effects of community mental health services on state hospital admissions: a clinical-demographic study.** *Hospital & Community Psychiatry*, Washington, D.C., 1978, Sept., vol. 29, no. 9, pp. 578-583.

To define the impact of community mental health centres on state psychiatric hospital admissions, data were collected on the clinical and demographic characteristics of patients admitted to a Pennsylvania state hospital from two counties. The study covered time spans both before and after the establishment of local community mental health services. Few consistent changes were found among the patient factors during the study period, indicating that the expansion of community services did not lead to a change in the type of patients admitted to the state hospital. However, the community mental health centres did appear to reduce both the admission rates to the hospital and the average length of stay. In addition, screening at the health centres for the possibility of local care prevented unnecessary admissions.

616. MCCRANIE, E. W. and MIZELL, T. A. **Aftercare for psychiatric patients: does it prevent rehospitalization?** *Hospital & Community Psychiatry*, Washington, D.C., 1978, Sept., vol. 29, no. 9, pp. 584-587.

A sample of 421 patients who had made from one to 65 visits to an after-care clinic was studied at the Medical College of Georgia to assess whether after-care reduced the numbers of patients re-entering hospital. A total of 167 patients were re-admitted during the study period. The findings showed that those who made most after-care visits were least likely to be re-admitted. This was especially true of psychotics, females, non-whites and older patients. Thus the effectiveness of after-care differs according to the demographic and diagnostic characteristics of the patients involved. The author stresses the need for patients to be interviewed about their ideas and expectations of after-care.

617. MEARS, E. **Sexual problem clinics: an assessment of the work of 26 doctors trained by the Institute of Psychosexual Medicine.** *Public Health*, London, 1978, Sept., vol. 92, no. 5, pp. 218-223.

This study is based on interviews at psychosexual problem clinics between 1,768 patients and 26 doctors trained in psychosexual work by the Institute of Psychosexual Medicine. The methods used are compared with an earlier study by Bancroft and Coles. Some couples were referred by their general practitioners and some, women

on their own, attended walk-in clinics. The number of patients completing treatment was 1,373. These were treated in 5,060 sessions, a mean of 2.5 hours per case. Substantial improvement was assessed in 893 (65 per cent) of the cases. Clinics concerned in this survey had a higher overall success rate than Bancroft, but had more drop-outs. Both studies show that many people need help with sexual problems. This can generally be given in relatively few sessions and when these are held in a local family planning clinic, the service is inexpensive and readily available.

618. KNESPER, D. J., LANDAU, S. G. and LOONEY, J. G. **Psychiatric education in the emergency room: must teaching stop at 5 p.m.?** *Hospital & Community Psychiatry*, Washington, D.C., 1978, Nov., vol. 29, no. 11, pp. 723-727.

The authors organized a questionnaire to find out about the availability of education resources for psychiatric residents in the emergency room during evenings and weekends. In 48 per cent of 87 training programmes, emergency room care was assigned to residents in the first year of training. The chief means of support was telephone help or the help of a non-psychiatrist professional. In only 16 per cent of the programmes was another psychiatrist present and supervision was generally not available until the following day. A decision to admit the patient may make up for the resident's inexperience but if comprehensive treatment is to begin in the emergency room, the education programme must be more positive and supervision more readily available.

619. IANZITO, B. M. and others. **Overnight admission for psychiatric emergencies.** *Hospital & Community Psychiatry*, Washington, D.C., 1978, Nov., vol. 29, no. 11, pp. 728-730.

Psychiatric patients who come to an emergency ward at the Baystate Medical Center, Springfield, Mass., are either released as an out-patient referral, admitted to a psychiatric hospital, or admitted to a holding unit for a maximum of 24 hours. The authors studied demographic and diagnostic data on 377 patients seen on the ward and compared those admitted to the holding unit (83) with those released (193) or sent to a psychiatric hospital (101). Those in the holding group fell between the other two groups in severity of psychopathology. The final disposition of the group was almost equally divided between admission and discharge to out-patient care. In cases of diagnostic uncertainty or short-term severity, overnight observation is a useful means of avoiding both unnecessary admission and inappropriate discharge.

620. CAWLEY, D. and KELLY, C. **Day care complements hospitalization.** *Hospitals*, Chicago, 1978, Oct. 1, vol. 52, no. 19, pp. 141-142, 144.

Timberlawn Day Hospital is part of the department of partial hospitalization of Timberlawn Psychiatric Hospital, Dallas, Tex. Attendance at the day hospital, which operates six days a week, can be full-time or part-time and is individualized according to each patient's level of functioning and needs. It continues to provide follow-up and after-care for discharged in-patients, but has also developed an eight-hour-a-day programme for out-patients, to provide an alternative to in-patient care. Distinguishing features of the programme include: (i) emphasis on shared responsibility (with the patient and his family) for treatment goals; (ii) support of the patient's maintenance of roles and responsibilities; (iii) encouragement of families to maintain regular contact and involvement with the treatment; (iv) an openness of patient

records; and (v) flexibility. A recent two-year study of discharge indicated that most patients were discharged following full or partial success of treatment. Median length of stay was 25 days for neurotic patients, 18 for psychotics and 15.8 for those with a personality disorder.

621. JOLLEY, D. and MORLEY, H. **Are too many demented patients in geriatric wards?** *Modern Geriatrics*, Bromley, 1978, Nov., vol. 8, no. 11, pp. 77-79.

A survey carried out in two geriatric hospitals in South Manchester revealed that a surprisingly large number of the ambulant demented elderly were patients in a geriatric hospital rather than in a psychiatric hospital or psycho-geriatric ward. This arises when demented people are accepted as a result of physical illness and then remain to become long-stay patients. A nation-wide survey could establish this misplacement of ambulant demented patients as a ratio per 1,000 elderly, with a regular review to allow for the increases in the very elderly population. A psycho-geriatric service which does not provide an adequate quota of beds or skilled nurses for continuing care runs the risk of failure.

622. **The use of management by objectives in developing services for the mentally handicapped at Darenth Park Hospital.** *Hospital & Health Services Review*, London, 1978, Dec., vol. 74, no. 12, pp. 425-427.

Darenth Park Hospital for the mentally handicapped has 1,000 patients and a catchment area covering four Area Health Authorities. In 1976 the hospital management team set out to achieve: (i) a team concept for improving delivery of care; (ii) the self-monitoring of performance by teams; (iii) provision of groups of wards and people; and (iv) decisions sympathetic to the needs of individual patients. A system of six-monthly seminars bringing together teams organized in different sectors of the hospital was put into operation. A strong feeling of team loyalty has developed and sectors have lowered bed numbers, improved their assessment patterns and started numerous ward projects. However, changes have not been so positive in every team and more experience is needed to determine the system's long-term value.

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